

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-038405

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2943

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		Length of stay in 1b <u>At home</u>		c. CITY OR TOWN <u>Webster Groves</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>30 So. Elm</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>30 So. Elm</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK L. ACHILLES</u>				4. DATE OF DEATH Month Day Year <u>Nov. 4, 1959</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-31-82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Canned goods</u>		11. BIRTHPLACE (City and state or country) <u>Austin, Texas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>August Achilles</u>			13b. MOTHER'S MAIDEN NAME <u>Emma Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Louise M. Achilles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>449-05-0697</u>		17. INFORMANT Address <u>O. D. Seabaugh, 123 Parkland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr -</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Nov 1st '59</u> to <u>Nov. 4 1959</u> and last saw him ^{was} alive on <u>Nov 4 1959</u> Death occurred at <u>9 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>O. D. Seabaugh M.D.</u>				22b. ADDRESS <u>Webster Groves Mo</u>				22c. DATE SIGNED <u>11 2 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-7-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Kirkwood, Mo.</u>		(State)		
24. FUNERAL DIRECTOR ADDRESS <u>Parker-Aldrich, Webster Groves</u>				25. DATE RECD. BY LOCAL REG. <u>11-6-59</u>		26. REGISTERS SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leslie Welch

Licensed Embalmer No. 4395
P. O. Address Abster Gro

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting. . . .
If this body is not embalmed, fact should be so stated above.