

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**  
**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-038429**

**FILED VS OCT 19 1959**

Registration District No. **317** Primary Registration District No. **590500** Registrar's No. **2589**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Florissant</b>		Length of stay in 1b <b>3 Months</b>		c. CITY OR TOWN <b>Florissant</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>260 N. Jefferson</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>260 N. Jefferson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Eugene</b> Last <b>Milslagle</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>29</b> Year <b>1959</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-33</b>		9. AGE (last birthday) <b>26</b>		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) <b>Sales Representative</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Inte r. Shoe Co.</b>		11. BIRTHPLACE (City and state or country) <b>South Bend, Ind.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>Walter Milslagle</b>				13b. MOTHER'S MAIDEN NAME <b>Beatrice O'Day</b>				14. NAME OF HUSBAND OR WIFE <b>Evelyn Milslagle</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes 1956-1959</b>				16. SOCIAL SECURITY NO. <b>387-28-8897</b>		17. INFORMANT <b>Evelyn Milslagle</b> Address <b>Florissant, Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intermittent Myocarditis</b> DUE TO (b) <b>Acute Hemorrhagic Pneumonitis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____		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 _____, to _____ and last saw her/him alive on _____ Death occurred at <b>12:04A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>John C. Murphy MD Agst. Health Commissioner</b>						22b. ADDRESS <b>801 S. Brentwood Clayton, Mo.</b>			22c. DATE SIGNED				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-1-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Lawn</b>		23d. LOCATION (City, town, or county) (State) <b>Racine, Wisconsin</b>							
24. FUNERAL DIRECTOR ADDRESS <b>The Florissant Mortuary Florissant, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-30-59</b>				26. REGISTRAR'S SIGNATURE <b>John C. Murphy MD</b>					

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

*Gene J. Hutchens*

Licensed Embalmer No. 4966

P. O. Address Flouissant,

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.