

FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038881

FILED VS DEC 2 1959

STATE FILE NUMBER

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 78

INDEXED

1. PLACE OF DEATH a. COUNTY <u>BOLLINGER</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>LITESVILLE</u> Length of stay in 1b <u>1 WEEK</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BOND NURSING HOME</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u> c. CITY OR TOWN <u>B. F. D. #1 ORAN, MO.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (if outside, give location) _____ Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH L. DONSBACH</u>			4. DATE OF DEATH Month Day Year <u>NOV. 19 1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/17/1866</u>	9. AGE (last birthday) <u>93</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARM LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>BISHOP CREEK, ILL. U. S. A.</u>			
13a. FATHER'S NAME <u>EDMUND DONSBACH</u>		13b. MOTHER'S MARDEN NAME <u>GERTRUDE GOEKNOB</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. ANIA MARIE STETIAN ORAN, MO.</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>NONE</u>		17. INFORMANT Address <u>MRS. ANIA MARIE STETIAN ORAN, MO.</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>Malignant ulceration over</u> DUE TO (b) <u>left side of neck.</u> DUE TO (c) <u>See above</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>15 months</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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Feb. 17 - 1959</u> to <u>Sept. 30 1959</u> and last saw him alive on _____ Death occurred at <u>4:15 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. J. O'Dell, M.D.</u>			22b. ADDRESS <u>Oran, Mo.</u>				
22c. DATE SIGNED <u>11-20-59</u> (State)			_____				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV. 21, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW GUARDIAN ANGELS</u>	23d. LOCATION (City, town, or county) <u>ORAN SCOTT MO.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Earl J. Smith</u>		25. DATE RECD. BY LOCAL REG. <u>11-30-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Buford Coker</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 8 1959

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 Carl J. Smith

Licensed Embalmer No. 3676

P. O. Address Orem, Utah

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.