

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-038959

FILED VS DEC 5 1959

STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 54

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Boone</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Centralia</b>	Length of stay in 1b <b>1 week</b>	c. CITY OR TOWN <b>Centralia</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>Campbell Hpsue</b>		d. STREET ADDRESS (If outside, give location) <b>425 N.Allen</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Myrtle</b> Last <b>Eckley</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1959</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/87</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months <b>11</b> Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kellerton, Ia.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Nathan Shelden</b>	13b. MOTHER'S MAIDEN NAME <b>Letha Jane Manning</b>	14. NAME OF HUSBAND OR WIFE <b>deceased</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>500-07-0357</b>	17. INFORMANT <b>Mrs. Margaret Schooler, Hallsville, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>cerebral artery thrombosis with respiratory paralysis</b>		<b>2 weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>cerebral arteriosclerosis with bulbar signs</b>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>arteriosclerotic heart disease with bronchiectasis right lower lobe</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ p.m.	Month, Day, Year _____
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20d. INJURY OCCURRED <input checked="" type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
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21. I attended the deceased from **10/14/59** to **11/27/59** and last saw her alive on **11/27/59**  
Death occurred at **12:20** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert H. Ward MD</i>	22b. ADDRESS <b>Centralia, Missouri</b>	22c. DATE SIGNED <b>11/30/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 1, '59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Centralia</b>	23d. LOCATION (City, town, or county) (State) <b>Centralia, Mo.</b>
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24. FUNERAL DIRECTOR <i>Bill J. Meade Centralia, Missouri</i>	25. DATE RECD. BY LOCAL REG. <b>Dec. 1 - 1959</b>	26. REGISTRAR'S SIGNATURE <i>Maud Mc Bride</i>
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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 Billy P. Meador

Licensed Embalmer No. 4876

P. O. Address Centerville, Miss

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.