

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959 042

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59-039042

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 1193

ENDED

1. PLACE OF DEATH a. COUNTY Buchanan b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in lb 51yrs c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Methodist Hosp. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Buchanan c. CITY OR TOWN St. Joseph Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS Rt #8 (if outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First James Middle Varley Last Pettet			4. DATE OF DEATH Month Nov. Day 26, Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1908	9. AGE (last birthday) 51	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) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Buchanan Co, Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Charles H. Pettet	13b. MOTHER'S MAIDEN NAME Harriett Elizabeth Collison	14. NAME OF HUSBAND OR WIFE Helen Pettet	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Helen Pettet, St. Joseph, Mo
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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: IMMEDIATE CAUSE (a) Cerebral Edema, Severe DUE TO (b) Hematomata: Bilateral subdural and right intracerebral DUE TO (c) Severe Trauma to Head		INTERVAL BETWEEN ONSET AND DEATH 20 hrs
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Back injury - (not x-rayed) - probably comp. fracture	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 checked="" 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.) Riding Tractor on highway - struck by car from behind
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20c. TIME OF INJURY Hour 8:30 a.m. / p.m. Month, Day, Year 11-23-59	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) farm - + highway	20f. CITY, TOWN, OR LOCATION Buchanan, Mo
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21. I attended the deceased from **3:30 A.M.** to **Nov 26, 1959** and last saw her/him alive on **Nov. 26, 1959**
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C.S. Grant M.D.	22b. ADDRESS 130V Faron, St. Joseph Mo	22c. DATE SIGNED 11-27-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/28/59	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo
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24. FUNERAL DIRECTOR ADDRESS John P. Papp St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Dec. 2, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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DOCUMENT

MEDICAL CERTIFICATION
C.S. Grant, M.D.

BY AFFIDAVIT OF

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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

~~_____~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *John E. Rupp*

Licensed Embalmer No. *3986*
P. O. Address *St. Joseph*

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.