

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-039347

FILED VS DEC 1 0 1959

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 5012 Registrar's No. 108

ENDED

1. PLACE OF DEATH a. COUNTY <u>Clay</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> Length of stay in 1b <u>5 weeks</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Excelsior Springs Hospital</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>Ray</u> c. CITY OR TOWN <u>Lawson</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>none</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROLLIE</u> Middle <u>ELMER</u> Last <u>HARTMAN</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1959</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>May 13, 1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pharmacy</u>		11. BIRTHPLACE (City and state or country) <u>Elms Kansas</u>			
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Hartman</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Dautel</u>			
14. NAME OF HUSBAND OR WIFE <u>Winnie Hartman Lawson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>497-36-6142</u>			
17. INFORMANT <u>Winnie Hartman - Lawson</u>		17. ADDRESS <u>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>Coronary occlusion</u> DUE TO (b) <u>Arterio sclerosis</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>34 days</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Previous cerebral hemorrhage 1952 & 1958</u> <u>left hemiparesis 7 days before occlusion</u>					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>8-18-59</u> to <u>11-15-59</u> and last saw him alive on <u>11-14-59</u> Death occurred at <u>2:35 a.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>George E. Sanders M.D.</u>			22b. ADDRESS <u>Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>11-17-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 18, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawson Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Lawson Mo</u>		
24. FUNERAL DIRECTOR <u>Jarman Funeral Home Lawson Mo</u> ADDRESS			25. DATE REC'D. BY LOCAL REG. <u>12-2-59</u>		26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

058 072

MS DEC 10 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 Lindsey Jarman

Licensed Embalmer No. 4589
P. O. Address Excelsior Springs, Mo

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.