

# FEDERAL BUREAU OF INVESTIGATION FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-042454

### FILED VS. NOV 16 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **2 9769**

2 9769

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE                      b. COUNTY c. CITY OR TOWN d. STREET ADDRESS							
a. COUNTY St. Louis				a. STATE                      b. COUNTY Mo.                              St. Louis							
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b Life		c. CITY OR TOWN St. Ann's		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Desloge Hospital				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 10347 St. Jean Lane		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> First                      Middle                      Last						<b>4. DATE OF DEATH</b> Month                      Day                      Year					
Eugene T. Scarry						October 23, 1959					
<b>5. SEX</b> M		<b>6. COLOR OR RACE</b> W		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 6-24-1907		<b>9. AGE (last birthday)</b> 52			
IF UNDER 1 YEAR Months      Days		IF UNDER 24 HR Hours      Min.									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Sverdrup & Parcel Eng. Co.			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Engineering Co.			<b>11. BIRTHPLACE</b> (City and state or country) St. Louis, Mo.		<b>12. CITIZEN OF WHAT COUNTRY</b> U.S.			
<b>13a. FATHER'S NAME</b> Thomas F. Scarry				<b>13b. MOTHER'S MAIDEN NAME</b> Anna Moran				<b>14. NAME OF HUSBAND OR WIFE</b> Mildred			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) Yes				<b>16. SOCIAL SECURITY NO.</b> W-11 187-22-5438		<b>17. INFORMANT</b> Mildred Scarry		Address 10347 St. Joan Lane			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								INTERVAL BETWEEN ONSET AND DEATH			
Tracheal obstruction								1 day			
Pressure by mediastinal tumor.								3 months			
Carcinoma, probably bronchogenic								? 1 yr.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) 162.1								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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour      Month, Day, Year a.m.      p.m.											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from</b> 10/1/59 to 10/22/59 and last saw her/him alive on 10/22/59 Death occurred at 3:05 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> C. Reilly Haulen M.D.				<b>22b. ADDRESS</b> 1825 S. GRAND BLVD & LOUIS 4				<b>22c. DATE SIGNED</b> 10/24/59			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE</b> 10-27-1959		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Calvary Cemetery		<b>23d. LOCATION</b> (City, town, or county) (State) St. Louis, Mo.					
<b>24. FUNERAL DIRECTOR</b> Arthur J. Donnelly, 3840 Lindell Blvd.				<b>25. DATE RECD. BY LOCAL REG.</b> OCT 26 1959		<b>26. REGISTRAR'S SIGNATURE</b> Leonard Smith, M.D.					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

later information sheet.

**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 W. J. Salton

Licensed Embalmer No. 4699

P. O. Address 3840 Linda

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.