

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 14 1959

59-043078

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 6179 Registrar's No. 115

EMENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Sullivan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Twp</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Sullivan</u> c. CITY OR TOWN <u>Jackson Twp</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> First <u>Bertha</u> Middle <u>May</u> Last <u>Olmstead</u>			<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>30</u> Year <u>1959</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>w</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-11-1883</u>	<b>9. AGE (last birthday)</b> <u>76</u>	<b>IF UNDER 1 YEAR</b> Months <u>10</u> Days <u>19</u>	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>at home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>Pollack - Mo</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>US</u>
<b>13a. FATHER'S NAME</b> <u>Lewis Calhoun</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Priscilla Starns</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>David H Olmstead (decd)</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			<b>16. SOCIAL SECURITY NO.</b> <u>49-42-3814</u>	<b>17. INFORMANT</b> <u>Walter Olmstead</u> Address <u>Pollack - Mo</u>		
<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) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>ARTERIO SCLEROSIS GENERAL</u> DUE TO (c) <u>HYPERTENSION SYSTOLIC</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>10 yr</u> <u>10 yr</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 checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____		<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> <u>JACKSON TWP</u>		<b>COUNTY</b> <u>SULLIVAN</u>	<b>STATE</b> <u>MO.</u>	
<b>21. I attended the deceased from</b> <u>June 1957</u> to <u>June 30, 1959</u> and last saw her alive on <u>June 30, 1959</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> <u>Stuart S. [Signature]</u> (Degree or title) _____			<b>22b. ADDRESS</b> <u>St. Louis, Mo.</u>		<b>22c. DATE SIGNED</b> <u>12/14/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>12-3-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bairdstown Cem</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Sullivan Co Mo</u> (State) _____	
<b>24. FUNERAL DIRECTOR</b> <u>Schoenew's</u> ADDRESS <u>Milan Mo</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-5-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. M.W. Beckett</u>		

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 Dwight Schone

Licensed Embalmer No. 2667

P. O. Address Milan - 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.