

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043183

STATE FILE NUMBER

Registration District No. 372 Primary Registration District No. 6263 Registrar's No. 90

RECEIVED

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY WEBSTER | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MO. b. COUNTY WEBSTER | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FINLEY TOWNSHIP | | Length of stay in 1b | c. CITY OR TOWN SEYMOUR |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) ROUTE 2 |
| | | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|---|----------------------------------|---|---|--|---|------------------------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL E. MCCLEARY | | | 4. DATE OF DEATH Month Day Year 11-22-59 | | | |
| 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 3-11-1882 | 9. AGE (last birthday) 77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED P | | 10b. KIND OF BUSINESS OR INDUSTRY DOUGLAS CO. MO. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME EDWARD MCCLEARY | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 14. NAME OF HUSBAND OR WIFE SADIE MCCLEARY | | |
| 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. 493-14-3155 | | 17. INFORMANT MRS. SADIE MCCLEARY SEYMOUR, MO. | | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks |
| DUE TO (b) arteriosclerosis | | |
| DUE TO (c) | | |
| 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 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.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |

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|--|--|--|--------------------------|---------------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input 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.) | 20f. CITY, TOWN, OR LOCATION SEYMOUR | COUNTY WEBSTER | STATE MO. |
| 21. I attended the deceased from Nov 21 to Nov 22 and last saw him alive on Nov 21-1959 Death occurred at 12:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|--|------------------------------|--|---|-------------------------------------|
| 22a. SIGNATURE (Degree or title) Robert Benjamin Seymour, M.D. | | 22b. ADDRESS Manfield, Mo. | | 22c. DATE SIGNED 11/23/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 11-24-59 | 23c. NAME OF CEMETERY OR CREMATORY STAR CEMETERY | 23d. LOCATION (City, town, or county) (State) WEBSTER CO. MO. | |

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|--|---------|---|---|
| 24. FUNERAL DIRECTOR Robert Benjamin Seymour, M.D. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 11-27-1959 | 26. REGISTRAR'S SIGNATURE Gilbert Jones |
|--|---------|---|---|

(Licensed Embalmer's Statement on Reverse Side)

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 Max L Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield

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.