

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 0 4 3 4 2 5  
STATE FILE NUMBER

FILED 1960 JAN 4 1960 District No. 042 Primary Registration District No. 1000 Registrar's No. 1287

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>		c. CITY OR TOWN <b>St. Joseph</b>	
Length of stay in 1b <b>25yrs</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5225 1/2 Lake Ave</b>		d. STREET ADDRESS (If outside, give location) <b>5252 1/2 Lake Ave</b>	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>E</b> Last <b>Sears</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>18,</b> Year <b>1959</b>			
--	--	--	---	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1881</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	--	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Re. Section Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (City and state or country) <b>Overland Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	--	--	--

13a. FATHER'S NAME <b>John Sears</b>	13b. MOTHER'S MAIDEN NAME <b>Julia Fair</b>	14. NAME OF HUSBAND OR WIFE <b>deceased</b>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Glendola Fotovich K.C. Kansas</b>
---	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unk.</b>
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)		
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 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 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 <b>9/11/57</b> to <b>Dec. 18, '59</b> and last saw her/him alive on <b>12/17/59</b> Death occurred at <b>4:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>S.E. Melaney M.D.</b>	22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>12/19/59</b>
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/20/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bowen Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo</b>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <b>John Edwards</b>	ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Dec. 28, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Dale Goodell</b>
---	----------------------------------	--	---

DOCUMENT

MEDICAL CERTIFICATION  
S.E. Melaney M.D.

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

*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.