

**FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE**

'59 0 4 3 8 3 2

FILED VS JAN - 4 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 282

STATE FILE NUMBER

ENDED

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|---|---|---|-------------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>FRANKLIN</u> | b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>WASHINGTON</u> | Length of stay in lb <u>6 DAYS</u> | c. CITY OR TOWN <u>SULLIVAN</u> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS HOSP.</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS <u>R. R. 2</u> |
| | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | |
| First <u>IRENE</u> | Middle <u>NEWMAN</u> | Last <u>NEWMAN</u> | Month <u>DEC.</u> | Day <u>27</u> |
| Year <u>1959</u> | | | | |
| 5. SEX <u>FEMALE</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>JUNE 18, 1890</u> | 9. AGE (last birthday) |
| | | | Months <u>69</u> | IF UNDER 1 YEAR Days <u>69</u> |
| | | | Hours <u>9</u> | IF UNDER 24 HR Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u></u> | 11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |

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| 13a. FATHER'S NAME <u>MICHAEL WARREN</u> | 13b. MOTHER'S MAIDEN NAME <u>MARY ANN McDONALD</u> | 14. NAME OF HUSBAND OR WIFE <u>G.C. NEWMAN</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT <u>G.C. NEWMAN, SULLIVAN MO.</u> |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | <u>PNEUMONIA</u> | <u>3 Days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>MYOCARDIAL DECOMPENSATION</u> | <u>3 Days</u> |
| | DUE TO (c) <u>ACUTE CORONARY THROMBOSIS</u> | <u>6 Days</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 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 | |
| 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 DEC 17-1959 to DEC 27 '59 and last saw her alive on DEC 26-1959
Death occurred at 2:36 A m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22. SIGNATURE <u>Robert M. [Signature]</u> | (Degree or title) | 22b. ADDRESS <u>Sullivan Mo.</u> | 22c. DATE SIGNED <u>Dec 27 '59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>DEC. 30, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u> |

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| 24. FUNERAL DIRECTOR <u>H.M. EATON SULLIVAN, MO.</u> | 25. DATE RECD. BY LOCAL REG. <u>12/28/59</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |
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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 _____

Harrison R. Eaton

Licensed Embalmer No. 5066

P. O. Address Sullivan, Pa.

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.