

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

'59 0 4 4 8 6 9

FILED VS DEC 2 8 1959

STATE FILE NUMBER

Registration District No. 247 Primary Registration District No. 5840 Registrar's No. 36

INDEXED

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| 1. PLACE OF DEATH a. COUNTY Newton | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Newton | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Van Buren Twp. | | Length of stay in 1b 50yrs | c. CITY OR TOWN Pierce City Rural |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6 mi west Wentworth | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Rural Route 2 Pierce City |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Anne Middle Mary Last Graskemper | | | 4. DATE OF DEATH Month 12 Day 11 Year 1959 | | |
|--|--|--|--|--|--|

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|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/10/1868 | 9. AGE (last birthday) 91 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Newvaria, Ohio | 12. CITIZEN OF WHAT COUNTRY USA |
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| 13a. FATHER'S NAME Valentine Eck | 13b. MOTHER'S MAIDEN NAME Catherine Seifert | 14. NAME OF HUSBAND OR WIFE Frank Graskemper |
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| 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. 492-42-8532 | 17. INFORMANT John Graskemper Sarcoxie, Missouri | Address |
|--|---|--|---------|

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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: IMMEDIATE CAUSE (a) Congestive Circulatory Failure | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| DUE TO (b) Prolonged myocardial infarction | | |
| DUE TO (c) Cardiomyopathy | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Debilitation of advanced years | | 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 |

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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.) |
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|---|------------------|
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> 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 | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from 10-10-57 to 12-11-59 and last saw her/him alive on 12-11-59
 Death occurred at 704 P_o m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|--------------------------------------|--------------------|----------------------------------|-------------------------------------|
| 22a. SIGNATURE <i>[Signature]</i> | (Degrees or title) | 22b. ADDRESS <i>[Address]</i> | 22c. DATE SIGNED 12-12-59 |
|--------------------------------------|--------------------|----------------------------------|-------------------------------------|

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|--|--------------------------------|---|--|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12/15/1959 | 23c. NAME OF CEMETERY OR CREMATORY St. Annes Cemetery | 23d. LOCATION (City, town, or county) Newton County, Mo. | (State) |
|--|--------------------------------|---|--|---------|

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| 24. FUNERAL DIRECTOR Wm. J. Wessell Pierce City, Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. Dec. 19-1959 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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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 me, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R. Gordon Bennett

Licensed Embalmer No. 4213

P. O. Address Mount, 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.