

**FEDERAL BUREAU OF INVESTIGATION**

**U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS JAN - 8 1960**

**'59 0 4 5 2 1 2**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **211990**

UNRECORDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>12 hrs.</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5006 Maple</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <b>EMILE G. BANDERET</b>			4. DATE OF DEATH Month Day Year <b>DECEMBER 24 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 type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5-30-1910</b>	9. AGE (last birthday) <b>49</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resturant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manager</b>	11. BIRTHPLACE (City and state or country) <b>New Orleans, La.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>John Banderet</b>		13b. MOTHER'S MAIDEN NAME <b>Camille Geisler</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>493-09-4133</b>	17. INFORMANT <b>Jack Banderet</b>	Address <b>Above</b>
---	---	---------------------------------------	-------------------------

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) <b>BULLOUS EMPHYSEMA WITH COR PULMONALE</b>		<b>15 YEARS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) _____		
DUE TO (c) _____ <b>527.1</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHRONIC ASTHMA</b>		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 checked="" 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 **JUNE 14, 1954** to **DEC. 24, 1959** and last saw her/him alive on **DEC. 24, 1959**  
Death occurred at **1:10 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. D. Camellion, M.D.</i> (Degree or title)	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>12/24/59</b> (State)
--	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>12-28-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>
---	------------------------------	--	---

24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 26 1959</b>	REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i>
---	--	--

*m. 9.03.*

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

LA 10-10-10 10:00:00

**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 A. P. Burgess

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.