

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

FILED VS JAN - 8 1960

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212101

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (if outside, give location) 4858 St. Louis Avenue | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Henrietta Middle Collier Last | | | | 4. DATE OF DEATH Month December Day 26 Year 1959 | | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12/6/1903 | 9. AGE (last birthday) 56 | 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) Unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) Mississippi | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME Bob Montgomery | | | 13b. MOTHER'S MAIDEN NAME Rosie Boyd | | | 14. NAME OF HUSBAND OR WIFE Willie Collier | | |
| 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. Unknown | | 17. INFORMANT Address Willie Collier 4858 St. Louis Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertension | | | | | | Interval 1 yr. | | |
| DUE TO (c) 331x | | | | | | | | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 Month, Day, Year a.m. p.m. | | | | | | | | |
| 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 May, 1959 to December, '59 and last saw her/him alive on Death occurred at 11:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE <i>W. H. [Signature]</i> (Degree or title) | | | | 22b. ADDRESS 950 Francis Place, Clayton | | | 22c. DATE SIGNED 12/29/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 12/12/60 | 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery | | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | | (State) 59/ | |
| 24. FUNERAL DIRECTOR <i>E. B. Koone</i> | | ADDRESS 1221 North Grand | | 25. DATE RECD. BY LOCAL REG. DEC 29 1959 | 26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i> | | | |

(Licensed Embalmer's Statement on Reverse Side)

UNRECORDED
 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

Clarence Brown

Licensed Embalmer No. 4755

P. O. Address 1231 N. K

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.