

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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 U.S. DEPARTMENT OF JUSTICE
 U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
 STANDARD CERTIFICATE OF DEATH

'59 0 4 5 3 5 2

211360

STATE FILE NUMBER

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

UNRECORDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Life		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Brothers Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3919 Botanical Ave.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Marcus Last Daake				4. DATE OF DEATH Month December Day 6th. Year 1959			
5. SEX M.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/5/1884	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of previous 12 months if retired) retired postal supervisor			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Florissant, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME John Daake			13b. MOTHER'S MAIDEN NAME Willemina Beller		14. NAME OF HUSBAND OR WIFE Minnie Daake		
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.		17. INFORMANT Address Dr. John W. Daake, # 48 Portland Place		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arterio sclerosis							_____
DUE TO (c) _____							420.0
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 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 Apr 20 1959 to Dec 6 1959 and last saw him alive on Dec 5 1959 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) B. J. Mc Ginnis M.D.				22b. ADDRESS 16 Hampshire Village Ave.		22c. DATE SIGNED 12-7-59	
23a. BURIAL, CREMATION, REBURNAL (Specify) Burial		23b. DATE 12/9/1959	23c. NAME OF CEMETERY OR CREMATORY St. Ferinand's Cemetery		23d. LOCATION (City, town, or county) (State) Florissant, Missouri		
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd.			25. DATE RECD. BY LOCAL REG. DEC 8 1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D. mdb		

DOCUMENT

MEDICAL CERTIFICATION

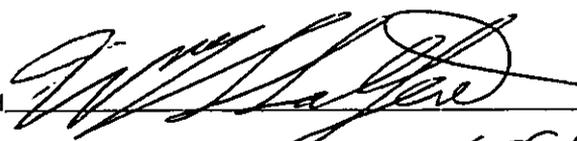
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address 3840 Linden

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.