

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

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DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JAN - 4 1960

211802

STATE FILE NUMBER

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

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 4 months	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 St. Louis State		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3247 Michigan Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Kathleen Middle Drennen Last			4. DATE OF DEATH Month December Day 20 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/2/1902	9. AGE (last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory work		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Tennessee	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Delphia Jackson Harper		13b. MOTHER'S MAIDEN NAME Aggie Hunt		14. NAME OF HUSBAND OR WIFE Claude Drennen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 487-26-2677	17. INFORMANT Address Claude Drennen, 3247 Michigan		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Central nervous system syphilis Meningoencephalitic				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 _____ 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 Aug. 3, 1959 to Dec. 20, 1959 and last saw ^{her} him alive on Dec. 20, 1959 Death occurred at Dec. 20, 1959 4:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>John H. McVahan</i> (Physician or other)		22b. ADDRESS 5400 Arsenal St.		22c. DATE SIGNED 12/20/59	
23a. BURIAL, CREATION, REMOVAL (Specify) Removal	23b. DATE 12/22/59	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.		23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.	
24. FUNERAL DIRECTOR McLaughlin's, 2301 Lafayette ADDRESS		25. DATE RECD. BY LOCAL REG. DEC 21 1959		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>	

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 A. G. Farnsworth

Licensed Embalmer No. 338

P. O. Address St. Louis

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.