

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JAN - 4 1960

59 0 4 5 4 9 9

STATE FILE NUMBER

211771

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

MEMORANDUM

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Cass			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b		c. CITY OR TOWN Beardstown		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 314 E. 3rd, St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUBREY Middle D. Last HAIST			4. DATE OF DEATH Month DECEMBER Day 15 Year 1959				
5. SEX Male	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 8/29/1892	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Train Master			10b. KIND OF BUSINESS OR INDUSTRY C.B.&Q.R.R.	11. BIRTHPLACE (City and state or country) Table Grove, Illinois.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Fillmore Haist			13b. MOTHER'S MAIDEN NAME Lucy (Unknown)		14. NAME OF HUSBAND OR WIFE Treo Haist		
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. NI.	17. INFORMANT Address Mrs. Treo Haist, 314 E. 3rd, St. Beardstown, Ill.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IRREVERSIBLE HEART FAILURE							INTERVAL BETWEEN ONSET AND DEATH 15 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) POST-OPERATIVE RIGHT PNEUMONECTOMY							2 DAYS
DUE TO (c) CARCINOMA OF RIGHT LUNG 163x							1 YEAR
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 NOV. 30, 1959 to DEC. 15, 1959 and last saw her/him alive on DEC. 15, 1959 Death occurred at 10:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>W. P. Vermillion, M.D.</i> M. D.				22b. ADDRESS BARNES HOSPITAL			22c. DATE SIGNED 12/16/59 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-18-59	23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) Centralian Illinois.			
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe Inc., 4700 Washington, Blvd.			25. DATE RECD. BY LOCAL REG. DEC 19 1959	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i> S.P.			

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 Stanley H. Rippe
Licensed Embalmer No. 4193

P. O. Address St. P.

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.