

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

**FILED VS DEC 3 0 1959**

**211437** <sup>59</sup> 0 4 5 5 5 3  
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)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST LOUIS</b>		Length of stay in 1b	a. STATE <b>MO</b>	b. COUNTY <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MALCOM-BLISS-HOSP</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Richmond-Heights ST LOUIS</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
			d. STREET ADDRESS <b>1330 ARGUS ST</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>ROBERT HITCHCOCK</b>			4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-2-23</b>	9. AGE (last birthday) <b>36</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state of birth) <b>RICHMOND HEIGHTS MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>HENRY HITCHCOCK</b>		13b. MOTHER'S MAIDEN NAME <b>LORINE HITCHCOCK</b>		14. NAME OF HUSBAND OR WIFE <b>BESSIE HITCHCOCK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>ARMY W.W.II</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>BESSIE HITCHCOCK, 2143 HICKORY</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Subdural hemorrhage caused by Fractured Skull.**

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 (Do not relate to the fatal disease condition given in PART I (a))  
**Suffered a fall down elevator shaft at Richmond Heights Hospital about December 7th 1959.**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. HOW INJURY OCCURRED (State nature of injury in PART I or PART II of item 18.) <b>about December 7th 1959.</b>	
20c. TIME OF INJURY Hour <b>9</b> a.m. <b>12</b> p.m. <b>7</b> Year <b>59</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg, etc.) <b>3rd Hospital</b>		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY/TOWN, OR LOCATION <b>St Louis Mo</b>	COUNTY _____ STATE _____

21. I attended the deceased from **724** to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree of title)	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>12/10/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>12-11-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>	23d. LOCATION (City, town, or county) (State) <b>JEFFERSON BGS - MO</b>
24. FUNERAL DIRECTOR <b>JACKSON FUNERAL 2649 DELMAR</b>		25. DATE RECD. BY LOCAL REG. <b>DEC 10 1959</b>	26. REGISTRAR'S SIGNATURE <b>Coart Smith, M.D.</b>

(H.T)

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 Leroy C. Bonnick

Licensed Embalmer No. 4523

P. O. Address 4251 WASH

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.