

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS DEC 21 1959

'59 045902
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **211169**

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hosptl		d. STREET ADDRESS (If outside, give location) 1504 B N. 23rd St.	
3. NAME OF DECEASED (Type or print) Orville G. Sample		4. DATE OF DEATH Month 11 Day 30 Year 59	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10b. KIND OF BUSINESS OR INDUSTRY Local 562	9. AGE (last birthday) 55
11. BIRTHPLACE (City and state or country) Doe Run Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Frank Sample		13b. MOTHER'S MAIDEN NAME Flora Paddock	
14. NAME OF HUSBAND OR WIFE Catherine Sample		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. 075-10-6939		17. INFORMANT Mrs. C. Sample 1504 B N. 23rd S	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination			INTERVAL BETWEEN ONSET AND DEATH Minutes
DUE TO (b) Hypo-Prothrombinemia			Weeks
DUE TO (c) Cirrhosis of Liver			4 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Inanition & Acites			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 _____ 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 1957 to 1959 and last saw him alive on Nov. 25, 1959 Death occurred at 11:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. H. Kohler		22b. ADDRESS 3448 Brown Rd. St. Louis 14, Mo.	22c. DATE SIGNED 11-30-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12/3/59	23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemeter.	23d. LOCATION (City, town, or county) St. Louis Co. Mo. (State)
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis AVE.	ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 2 1959	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

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 Gustav W. Quilley

Licensed Embalmer No. 4321

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.