

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

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Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 45 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Worth</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Worth</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sheridan</b>		Length of stay in 1b <b>Life</b>	c. CITY OR TOWN <b>Sheridan</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>John Richard Elliott</b>			4. DATE OF DEATH <b>December 22, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>Apr 14, 1883</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (City and state or country) <b>Petersburg, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S.</b>		
13a. FATHER'S NAME <b>Thomas Elliott</b>		13b. MOTHER'S MAIDEN NAME <b>Susan Zirkel</b>		14. NAME OF HUSBAND OR WIFE <b>Della Elliott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Della Elliott-Sheridan, Missouri</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>MEDULLARY FAILURE</b>		<b>6 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CEREBRO VASCULAR ACCIDENT</b>		<b>6 DAYS</b>
DUE TO (c) <b>ARTERIOSCLEROSIS - MARKED</b>		<b>12 YEARS</b>
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
20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		

21. I attended the deceased from **MAY 1951** to **DEC 22, 1959** and last saw her/him alive on **DEC 21, 1959**  
Death occurred at **9:20 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Richard J. Smith M.D.</b>		22b. ADDRESS <b>GRANT CITY MO</b>		22c. DATE SIGNED <b>12-23-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>12-24-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Vernon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Worth County, Missouri</b>	

24. FUNERAL DIRECTOR <b>Bill D. Dunfee - Grant City, Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Jan 8 1960</b>	26. REGISTRAR'S SIGNATURE <b>Bowdrey Kibbe</b>	
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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 Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address South Co  
Miss

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.