

# FEDERAL BUREAU OF INVESTIGATION

## FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 18 1960

211976 - 59-047009

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

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Barnes Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>  c. CITY OR TOWN <b>Frontenac:</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>1715 North Geyer Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>GRACE VIRGINIA MANSUR</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>DECEMBER 26, 1959</b>		
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Dec 20, 1920</b>	<b>9. AGE (last birthday)</b> <b>39</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at home</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Urbana, Illinois</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>Arlie Glenn Capps</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Ruby Barnes</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Charles I. Mansur</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>yes</b>	<b>17. INFORMANT</b> <b>Frontenac, Mo.</b> <b>Charles I. Mansur, 1715 N. Geyer Rd.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tumor (Meningioma) Brain</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>PICK</b> DUE TO (c) <b>Stroke on Dec 22, 59</b>					INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Agony (over 28) 59</b>				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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>Stroke</b>			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> _____	<b>COUNTY</b> _____	<b>STATE</b> _____
<b>21. I attended the deceased from</b> <b>October 1958</b> , to <b>12-26-59</b> and last saw her <sup>him</sup> alive on <b>12-26-59</b> Death occurred at <b>7:00 AM</b> <b>12-26-59</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) 			<b>22b. REGISTER'S SIGNATURE</b> <b>JOHN S. SKINNER, M.D.</b> <b>35 N. CENTRAL AVE.</b>		<b>22c. DATE SIGNED</b> <b>DEC 27 1959</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>removal</b>	<b>23b. DATE</b> <b>Dec. 28, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Columbia, Missouri</b>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>C.R. Lupton and Sons 7233 Delmar Bly'd.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>DEC 28 1959</b>	<b>26. REGISTER'S SIGNATURE</b> 		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m.s. 13*

**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 Arnold W. Scho

Licensed Embalmer No. 3864

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.