

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

60-000839

FILED VS. JAN 19 1960 88

Primary Registration District No. 5330 Registrar's No. 4

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Crawford				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Crawford									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN OSAGE TOWNSHIP		Length of stay in 1b 5 yrs.		c. CITY OR TOWN Dillard		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Farm home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Rural Route		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JACOB Middle ROST Last ROST				4. DATE OF DEATH Month Jan. Day 18 Year 1960									
5. SEX male		6. COLOR OR RACE white		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH AUG. 21 1892		9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (City and state or country) DRAKE MO		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME ROST				13b. MOTHER'S MAIDEN NAME NOT KNOWN				14. NAME OF HUSBAND OR WIFE DEAD					
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. NONE		17. INFORMANT Address AUG. SEWING DILLARD MO.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion Immediate DUE TO (b) Coronary Atherosclerosis DUE TO (c) Generalized Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (if not related to the terminal disease condition given in PART I (a)) Pneumonia 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										INTERVAL BETWEEN ONSET AND DEATH			
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 checked="" 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 1/13/60 to present and last saw him alive on 1/18/60 . Death occurred at 122 on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE B. J. BOSS MD (Degree or title)						22b. ADDRESS Salem Mo.			22c. DATE SIGNED 1/18/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-19-1960		23c. NAME OF CEMETERY OR CREMATORY Zoar Methodist Cem.				23d. LOCATION (City, town, or county) (State) near Drake, Mo.					
24. FUNERAL DIRECTOR Gottenstroeter F. Home Owensville Myford H H Winter Mo.					25. DATE RECD. BY LOCAL REG. 1-18-1960		26. REGISTRAR'S SIGNATURE Mrs. Hazel Lechman						

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 me, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Melvin H. H. J.

Licensed Embalmer No. 380

P. O. Address OWENS

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.