

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 19 1960

=60-002606

Registration District No. 226 Primary Registration District No. 4352 Registrar's No. 1

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MORGAN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MILLER</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VERSAILLES</u>		Length of stay in 1b <u>5 weeks</u>		c. CITY OR TOWN <u>TUSCUMBIA</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kidwell-Nursing-Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3 mi - So - Tuscombia -</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY-</u> Middle <u>LAURA-</u> Last <u>JOHLY</u>				4. DATE OF DEATH Month <u>JAN-</u> Day <u>13</u> Year <u>1960</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5 Sept - 1862</u>	9. AGE (last birthday) <u>97</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At - Home</u>		11. BIRTHPLACE (City and state or country) <u>MILLER-Co-Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		
13a. FATHER'S NAME <u>MARCUS - Palmer</u>			13b. MOTHER'S MAIDEN NAME <u>MARY - HARRISON</u>			14. NAME OF HUSBAND OR WIFE <u>John - JOHLY</u> Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Stella - Musick - Tuscombia - Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hour</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Coronary thrombosis</u>					1 hour	
		DUE TO (c) <u>Arteriosclerosis</u>					10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Varicosities and hemorrhages from esophagus</u>					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			
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.) <u>NONE</u>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>NONE</u>		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.) <u>NONE</u>		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>Dec 15 1959</u> to <u>Jan 12, 1960</u> and last saw her/him alive on <u>Jan 12, 1960</u> Death occurred at: <u>3:20 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>P. F. Eckloff</u>				22b. ADDRESS <u>D. O. Versailles - Mo</u>		22c. DATE SIGNED <u>1-13-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL -</u>		23b. DATE <u>15 JAN-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forrest - Hill -</u>		23d. LOCATION (City, town, or county) (State) <u>Kennett - Rty - Mo</u>			
24. FUNERAL DIRECTOR <u>Keith McKay</u>		ADDRESS <u>ELDON - Mo</u>		25. DATE RECD. BY LOCAL REG. <u>1-14-60</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Wash</u>			

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 Keith M. Hayes

Licensed Embalmer No. 3998

P. O. Address Eldon

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.