

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

-60-003505

FILED VS. FEB. 5 1960

Primary Registration District No.

Registrar's No.

2 799

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kentucky</b> b. COUNTY <b>McCracken</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 days</b>		c. CITY OR TOWN <b>Paducah</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 <b>St. Louis Childrens'</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1021 Harrison St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Ronald</b> Middle <b>Ray</b> Last <b>Hankins</b>			4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-51</b>	9. AGE (last birthday) <b>8 yrs.</b>	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) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Paducah, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>

13a. FATHER'S NAME <b>John Davis Hankins</b>		13b. MOTHER'S MAIDEN NAME <b>Manon Ray</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Vernell Kunzie</b> Address <b>highway 500 s.Kings-</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congenital Heart Disease</b>			
DUE TO (c) <b>Post Op. Tetralogy of Fallot</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. <b>754.0</b> <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.) <b>754.0</b>	
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 <b>Paducah</b>	COUNTY <b>McCracken</b>	STATE <b>Kentucky</b>
21. I attended the deceased from <b>1-16-60</b> , to <b>1-21-60</b> and last saw her/him alive on <b>1-21-60</b> Death occurred at <b>6:00pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Leonard Peter Brown M.D.</b> (Degree or title)		22b. ADDRESS <b>500 So. Kingshighway</b>		22c. DATE SIGNED <b>1-20-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-23-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) (State) <b>Paducah, Kentucky</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>JAN 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Keal Smith M.D.</b> <i>W.D.C.</i>	

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 \_\_\_\_\_

*Elmer A. Sade*

Licensed Embalmer No. 407

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.