

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

-60-003507

FILED VS JAN 29 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 717** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN d. STREET ADDRESS		
a. COUNTY: <b>St. Louis MO</b> b. CITY: <b>St. Louis MO</b> c. FULL NAME: <b>218 So. 4th</b>			a. STATE: <b>MO</b> b. COUNTY: <b>St. Louis</b> c. CITY OR TOWN: <b>St. Louis</b> d. STREET ADDRESS: <b>218 So. 4th</b>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year			5. SEX 6. COLOR OF SKIN 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		
3. NAME OF DECEASED: <b>Robert Hantack</b> 4. DATE OF DEATH: <b>1/1/60</b>			5. SEX: <b>Male</b> 6. COLOR OF SKIN: <b>White</b> 7. Married: <input checked="" type="checkbox"/> Never Married: <input checked="" type="checkbox"/> Widowed: <input type="checkbox"/> Divorced: <input type="checkbox"/>		
8. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (last birthday) IF UNDER 4 YEAR IF UNDER 24 HR Months Days Hours Min.	
8. USUAL OCCUPATION: <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>None</b>		9. AGE: <b>52</b>	
10a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
10a. FATHER'S NAME: <b>Wick</b>		13b. MOTHER'S MAIDEN NAME: <b>Wick</b>		14. NAME OF HUSBAND OR WIFE: <b>Wick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Wick</b>			16. SOCIAL SECURITY NO.: <b>Wick</b>		17. INFORMANT Address: <b>Dr. Saylor 61300 Clark</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) DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a): <b>Lobar Pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): <b>Bilateral And Pleurisy</b>					INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (c): <b>With Effusion Right</b>					INTERVAL BETWEEN ONSET AND DEATH:
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
PART II: <b>W.M.A</b>					PART III: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
19. WAS AUTOPSY PERFORMED? <b>YES</b>	20a. ACCIDENT: <input type="checkbox"/> SUICIDE: <input type="checkbox"/> HOMICIDE: <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: <b>490x</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.)	
20c. TIME OF INJURY:		20d. INJURY OCCURRED: <input type="checkbox"/>		20e. PLACE OF INJURY:	
20f. CITY, TOWN, OR LOCATION		20g. COUNTY		20h. STATE	
20f. CITY, TOWN, OR LOCATION:		20g. COUNTY:		20h. STATE:	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.					
21. I attended the deceased from <b>1/1/60</b> to <b>1/1/60</b> and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			22a. SIGNATURE (Degree or title)		22b. ADDRESS
21. I attended the deceased from <b>1/1/60</b> to <b>1/1/60</b> and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			22a. SIGNATURE: <b>Paul Simon Deputy Coroner</b>		22b. ADDRESS: <b>1300 Clark</b>
22c. DATE SIGNED		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
22c. DATE SIGNED: <b>1/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY: <b>Anatomical Board</b>		23d. LOCATION: <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS: <b>Rowland-Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo</b>			25. DATE RECD. BY LOCAL REG.: <b>JAN 21 1960</b>		26. REGISTRAR'S SIGNATURE: <b>Earl Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

St. Louis 10, Mo

(Licensed Embalmer's Statement on Reverse Side)

mjb

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.