

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**  
**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-007657**

**FILED VS MAR 15 1960**

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 28 STATE FILE NUMBER \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hy 66 Waynesville</b>		Length of stay in 1b <b>30 MIN</b>	c. CITY OR TOWN <b>Waynesville</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>Waynesville MO</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Jerry</b> Middle <b>Joseph</b> Last <b>Irish</b>	4. DATE OF DEATH Month <b>Feb</b> Day <b>29</b> Year <b>1960</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>4/7/1941</b>	9. AGE (last birthday) <b>18</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)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Louisville, Ky</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>Joseph H. Irish</b>	13b. MOTHER'S MAIDEN NAME <b>Mary E. Cain</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) <b>no</b>	16. SOCIAL SECURITY NO. <b>406540209</b>	17. INFORMANT <b>Joseph H. Irish</b> Address <b>Waynesville, Mo</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>Fractured Skull - Crushed Chest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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
---	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Automobile Accident</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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>	20f. CITY, TOWN, OR LOCATION <b>WAYNESVILLE</b> COUNTY <b>PULASKI</b> STATE <b>MO</b>
---	---	---

21. I attended the deceased from **ON FEB 29 1960** to \_\_\_\_\_ and last saw him alive on \_\_\_\_\_  
 Death occurred at **10:45 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>CORONER RICHLAND MO</b>	22b. ADDRESS _____	22c. DATE SIGNED <b>3/3/60</b> (6date)
--	--------------------	--

23a. BURIAL, CREMATION REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>3/3/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary CEMETERY</b>	23d. LOCATION (City, town, or county) <b>Louisville, Ky</b>
---	-------------------------	--	---

24. FUNERAL DIRECTOR <b>Walter Hedges</b> ADDRESS <b>Hedges Funeral Home Waynesville, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>3-3-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
--	--	--

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

VS MAR 15 1960

**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 Clarence Prosser

Licensed Embalmer No. 4896

P. O. Address Weymouth

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.