

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

XC-525 861

SL 8572

-60-008087

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **3-1522**

FILED VS FEB 18 1960

1. PLACE OF DEATH a. COUNTY		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 915 N.GRAND, ST. LOUIS, MO.		Length of stay in 1b 12 days	c. CITY OR TOWN CUBA Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) ROUTE #2 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JACOB Middle C. Last CROSS			4. DATE OF DEATH Month FEBRUARY Day 9 Year 1960	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/7/87	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) JAKES PRAIRIE, MO.	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME JOHN CROSS	13b. MOTHER'S MAIDEN NAME SUSAN LORTS	14. NAME OF HUSBAND OR WIFE BLANCHE CROSS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	16. SOCIAL SECURITY NO. 493-01-7068	17. INFORMANT Blanche Cross, Rt. #2, Cuba, Missouri	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CEBRAL ANOXIA		48 HOURS
DUE TO (b) SEVERE PULMONARY EMPHYSEMA, OBSTRUCTIVE		YEARS
DUE TO (c) - 527.1 -		-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). CHOLELITHIASIS, CHRONIC CHOLECYSTITIS, CALCULUS OF COMMON BILE DUCT		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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 VA	COUNTY	STATE
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21. I attended the deceased from **1/28/60** to **2/9/60** and last saw him alive on **2/9/60**
Death occurred at **5:50 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William A. Sherman M.D.	22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 2/9/60
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2-11-1960	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Cuba, Missouri
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24. FUNERAL DIRECTOR Paul A. Sherman, Cuba, Mo.	25. DATE RECD. BY LOCAL REG. FEB 9 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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DOCUMENT

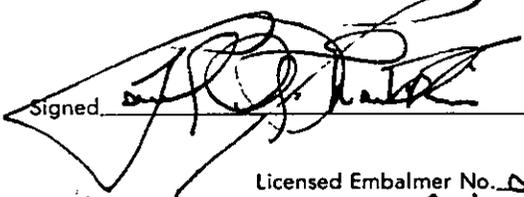
MEDICAL CERTIFICATION

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 _____, Student Embalmer No. _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 347
P. O. Address Cuba, M

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.