

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS FEB 25 1960**

**-60-008535**

**2 1064**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>				Length of stay in 1b		c. CITY OR TOWN <b>Greendale</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7408 Marillac Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle _____ Last <b>LOMAX</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Female</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>1-16-1884</b>	
9. AGE (last birthday) <b>76</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>Retired School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beaumont High School</b>		11. BIRTHPLACE (City and state or country) <b>Hawk Nest, W.Va.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13a. FATHER'S NAME <b>James Lomax</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>-----</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>   <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Thomas L. Peacock</b> Address <b>7408 Marillac Dr.</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>Myocardial Infarction Acute</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Thrombosis</b>						"	
DUE TO (c) <b>Arteriosclerotic Heart Disease</b>						<b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>H2O.O</b>						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.)			
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		COUNTY STATE	
21. I attended the deceased from <b>Jan. 24, 1960</b> to <b>Jan 29, 1960</b> and last saw her alive on <b>Jan 28, 1960</b> Death occurred at <b>7:45 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Alphonse McArthur MD</b> (Degree or title)				22b. ADDRESS <b>634X Grand Blvd</b>		22c. DATE SIGNED <b>1-29-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Removal (Rail)</b>		<b>1-31-1960</b>		<b>McArthur, Ohio</b>			
24. FUNERAL DIRECTOR <b>Kriegshauser 9450 Olive St. Rd.</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>JAN 29 1960</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

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 *A. W. Stovessand*

Licensed Embalmer No. 4007

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.