

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

**60-011788**

FILED VS MAR 18 1960 209

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 93

STATE FILE NUMBER

ENDED

|   |  |   |  |  |   |  |   |
|---|--|---|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Marion</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Marion</b> |   |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Hannibal</b>  |  | Length of stay in 1b<br><b>3 wks</b>  |  | c. CITY OR TOWN <b>Hannibal</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>St. Elizabeth Hospital</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><b>715 Center</b>   |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sarah</b> Middle <b>Jane</b> Last <b>Dempsey</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>3</b> - Day <b>7</b> - Year <b>1960</b>   |   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-16-1880</b>   | 9. AGE (last birthday)<br><b>79</b>                                     | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/>     | IF UNDER 24 HR<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>        |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><b>Fowler, Ill.</b>       |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |
| 13a. FATHER'S NAME<br><b>Edward Dempsey</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Anna Reynolds</b>                                    |  | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>                              |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.  | 17. INFORMANT Address<br><b>Opal Kelley - Hannibal, Mo.</b>  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of cecum</b><br>DUE TO (b) <b>Arteriosclerotic vascular disease, severe</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 wks</b><br><b>5 yrs</b>                      |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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.)  |  | 20f. CITY, TOWN, OR LOCATION   |   | COUNTY   | STATE   |
| 21. I attended the deceased from <b>2-18-60</b> to <b>3-7-60</b> and last saw <b>her</b> alive on <b>3-7-60</b><br>Death occurred at <b>3:20 A</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |  |   |  |   |
| 22a. SIGNATURE (Degree or title)<br><i>Ruth Lanning</i>   |  |   | 22b. ADDRESS<br><b>115 N. 5th St. Hannibal, Missouri</b>                             |  | 22c. DATE SIGNED<br><b>3-8-60</b>                                       |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial Removal</b>  | 23b. DATE<br><b>3-9-1960</b>           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter's Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Quincy, Ill.</b>   |   | (State)  |   |
| 24. FUNERAL DIRECTOR<br><b>Clark Funeral Home - Hannibal, Mo.</b>   |  |   | ADDRESS  | 25. DATE RECD. BY/LOCAL REG.<br><b>3/10/60</b>   | 26. REGISTRAR'S SIGNATURE<br><i>Dr. E.M. Lucke by Lillian M. Thomas</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  \_\_\_\_\_

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo

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