

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

FILED VS APR 4 1960

60-012010

STATE FILE NUMBER

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 144

ENDED

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		Length of stay in 1b <u>2 days</u>		c. CITY OR TOWN <u>Warsaw</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Rest Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>---</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE WALTER ALEXANDER</u>				4. DATE OF DEATH Month Day Year <u>March 30 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 24, 1880</u>	
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (City and state or country) <u>Warsaw, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		13a. FATHER'S NAME <u>James M. Alexander</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. See</u>	
14. NAME OF HUSBAND OR WIFE <u>Never married</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Lon. Alexander</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction, multiple</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prostate hypertrophy (? carcinoma)</u>		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 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 <u>1946</u> to <u>3/29/60</u> and last saw her alive on <u>3/29/60</u> Death occurred at <u>9:38</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. B. Rhodes, M.D.</u> (Degree or title)				22b. ADDRESS <u>Warsaw, Mo.</u>		22c. DATE SIGNED <u>4-1-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Balliett Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Warsaw Benton Co, Mo</u>	
24. FUNERAL DIRECTOR <u>John J. Reser</u> ADDRESS <u>Warsaw, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>April 2 - 1960</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 John J. Reser

Licensed Embalmer No. 409

P. O. Address Warsaw

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.