

**FEDERAL BUREAU OF INVESTIGATION**  
**U.S. DEPARTMENT OF JUSTICE**  
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**U.S. DEPARTMENT OF JUSTICE**

FILED VS APR 4 1960

160-012840

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 3417**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>JEFFERSON</b>									
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>Morse Mill</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LUTHERAN HOSP.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>KOLLINGER</b> Last <b>SR.</b>				4. DATE OF DEATH Month <b>MAR</b> Day <b>23</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-13-1889</b>		9. AGE (last birthday) <b>70</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 ENAMELER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>AUSTRIA-HUNGARY</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>FRANK KOLLINGER</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE <b>MARGARET KOLLINGER</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>---</b>		17. INFORMANT Address <b>MARGARET KOLLINGER Morse Mill, 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>Acute Myocardial Infarction</b>										INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arterio-sclerotic Heart Disease</b>										5 yrs			
DUE TO (c) <b>H2O, U</b>													
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 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>3/14/60</b> to <b>3/23/60</b> and last saw her/him alive on <b>3/23/60</b> Death occurred at <b>10:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Fred. Mortensen MD</b>						22b. ADDRESS <b>3701 Grandel Square, St. Louis</b>			22c. DATE SIGNED <b>3/25/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>MAR 26, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL PARK</b>				23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS CO. MO.</b>					
24. FUNERAL DIRECTOR <b>Thomas Kulis 2986 Gravois</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 25 1960</b>		26. REGISTRAR'S SIGNATURE <b>Karl Smith MD</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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123040003  
Gru

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grav

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.