

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

**=60-015839**

**FILED VS APR 26 1960**

*156*

Registration District No. *156* Primary Registration District No. *2001*

Registrar's No. *195*

STATE FILE NUMBER

UNDECEASED

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>INDIANA</b> b. COUNTY <b>WHITE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b>	Length of stay in 1b <b>4 DAYS</b>	c. CITY OR TOWN <b>MONTICELLO</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FREEMAN HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>RR 1, MONTICELLO</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>GRACE ETTA DRAKE</b>			4. DATE OF DEATH Month Day Year <b>APRIL 15, 1960</b>			
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-88</b>	9. AGE last birthday <b>71</b>	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) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and state or country) <b>WISCONSIN</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ABNER MCWETHY</b>	13b. MOTHER'S MAIDEN NAME <b>ROSE BAKER</b>	14. NAME OF HUSBAND OR WIFE <b>URBAN DRAKE</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>307-22-6413A</b>	17. INFORMANT Address <b>CHARLES BANKER, MONTICELLO, IND.</b>
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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) <b>Hemorrhage in to the Brain Stem</b>		<b>75 hrs. &amp; 15 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerosis</b>	<b>Unknown</b>
	DUE TO (c) <b>Hypertension</b>	<b>Unknown</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input 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 Month, Day, Year a.m. p.m.	
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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 COUNTY STATE
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21. I attended the deceased from **4-12-60** to **4-15-60** and last saw her him alive on **4-15-60**  
 Death occurred at **7:45 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Drops or title) <i>John J. Smith</i>	22b. ADDRESS <i>Joplin Mo</i>	22c. DATE SIGNED <i>4/16/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>4-16-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK ADDITION, PLYMOUTH, INDIANA</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS <b>STEVE PARKER MORTUARY, JOPLIN, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>4-21-1960</b>	26. REGISTRAR'S SIGNATURE <i>Noel Merriam</i>
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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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey E. Arner

Licensed Embalmer No. 4463

P. O. Address Jeffers, Mo

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.