

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

-60-017908

FILED VS MAY 6 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1459 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lemay	Length of stay in 1b	c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Torrence Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 12499 Riverview Dr. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Emily Middle Mitchell Last Mitchell	4. DATE OF DEATH Month April Day 27 Year 1960
---	---

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (last birthday) 94?	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
----------------------	-------------------------------	---	---------------------------------	-----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unavailable	10b. KIND OF BUSINESS OR INDUSTRY Unavailable	11. BIRTHPLACE (City and state or country) Unavailable	12. CITIZEN OF WHAT COUNTRY U.S.
---	---	--	--

13a. FATHER'S NAME Thomas F. Mitchell	13b. MOTHER'S MAIDEN NAME Mary Garvin	14. NAME OF HUSBAND OR WIFE None
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Public Adm. Office Records, St. Louis, Mo.
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis Heart Disease	INTERVAL BETWEEN ONSET AND DEATH 1 yr 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis	
DUE TO (c)	

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
---	---

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 <input type="checkbox"/> 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 25 April 60 to 27 April and last saw her alive on 25 April 1960 . Death occurred at 7:00 p m on the date stated above, and to the best of my knowledge, from the causes stated.
--

22. SIGNATURE (Degree or title) William F. McNamee MD	22b. ADDRESS 7619 Gray Ave.	22c. DATE SIGNED 5/3/60
---	---------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 5-4-60	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	----------------------------	--	--

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. 5-3-60	26. REGISTRAR'S SIGNATURE John E. Murphy MD.
---	---	--

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 Melvin L. Kemp

Licensed Embalmer No. 4052

P. O. Address 4911 Wa

St. Louis, Mo

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