

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

**-60-019113**

STATE FILE NUMBER

FILED VS JUN 13 1960

Registration District No. 128 Primary Registration District No. \_\_\_\_\_ Registrar's No. 634

UNDECEASED

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Length of stay in 1b		c. CITY OR TOWN <b>FAIR GROVE</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>SUNSHINE ACRES</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>ROUTE 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>VINEY</b> Middle _____ Last <b>COMPTON</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>4</b> Year <b>1960</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</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>2-13-1878</b>	9. AGE (last birthday) <b>82</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>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>IN HOME</b>		11. BIRTHPLACE (City and state or country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>ROBERT LEWALLEN</b>			13b. MOTHER'S MAIDEN NAME <b>ANNA DAVIS</b>			14. NAME OF HUSBAND OR WIFE <b>WIDOWED</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>NONE</b>		17. INFORMANT Address <b>GERTRUDE GIBSON SPRINGFIELD, MISSOURI</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>Cardio-Vascular Disease</b> DUE TO (b) <b>Fractured Hips</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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.) <b>Fell</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <b>2/25/60</b>									
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.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Fair Grove</b>		COUNTY <b>Greene</b>		STATE <b>Mo.</b>	
21. I attended the deceased from <b>Feb. 25, 1960</b> to <b>June 4, 1960</b> and last saw her <sup>him</sup> alive on <b>June 1, 1960</b> Death occurred at <b>7:40 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Leman D. Brown M.D.</b> (Degree or title)				22b. ADDRESS <b>311 1/2 College</b>				22c. DATE SIGNED <b>6/7/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6-7-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DANFORTH CEMETERY</b>			23d. LOCATION (City, town, or county) <b>SPRINGFIELD, MISSOURI</b> (State)			
24. FUNERAL DIRECTOR <b>KLINGNER MORTUARY, INC. SPRINGFIELD, MO</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>6-9-60</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>			

(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 B. Klung

Licensed Embalmer No. 27102

P. O. Address Springfield

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.