

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

FILED VS MAY 25 1960

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=60-021119

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Saint Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis | | c. CITY OR TOWN St. Louis | |
| Length of stay in 1b _____ | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips | | d. STREET ADDRESS (If outside, give location) 1907 a Cole | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|---------------------------------|---|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Andrea Middle Lenont Last Jones | | | 4. DATE OF DEATH Month 5 Day 3 Year 60 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-12-60 | 9. AGE (last birthday) | IF UNDER 1 YEAR Months 9 Days 22 | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME Willie D. Robinson | | 13b. MOTHER'S MAIDEN NAME Mary Margaret Jones | | 14. NAME OF HUSBAND OR WIFE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Willie D. Robinson- 1907 a Cole | | |

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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: IMMEDIATE CAUSE (a) Suffocation | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) _____ | | |
| DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Support taken and was found in home May 3rd 1960. | | 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 checked="" type="checkbox"/> | 20a. ACCIDENT <input checked="" 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.) found in bed in home May 3rd 1960. | |
| 20c. TIME OF INJURY Hour 3 s.m. _____ p.m. _____ Month, Day, Year 5 3 60 | 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.) Home | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE St Louis Mo. | |

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-----------------------------|---|---|-------------------------------------|
| 22a. SIGNATURE (Degree or title) Patrick Taylor Connor | | 22b. ADDRESS 1300 Clark | | 22c. DATE SIGNED 5.12.60. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 5-12-60 | 23c. NAME OF CEMETERY OR CREMATORY Father Dickson | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo | |
| 24. FUNERAL DIRECTOR ADDRESS Jackson Funeral Home- 2649 Delmar | | 25. DATE RECD. BY LOCAL REG. MAY 12 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

