

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

FILED VS JUN 15 1960

=60-021251

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5886 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>			Length of stay in 1b <u>10 Days</u>		c. CITY OR TOWN <u>Venice</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1212 Calhoun St.</u>
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		5. SEX
First <u>ROBERT</u> Middle <u>NMN</u> Last <u>MCKENZIE</u>			Month <u>JUNE</u> Day <u>5</u> Year <u>1960</u>		Male
6. COLOR OR RACE <u>Negro</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/1/10</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Packing Co.</u>		11. BIRTHPLACE (City and state or country) <u>Venice, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Robert McKenzie</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Catherine McKenzie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Catherine McKenzie-1212 Calhoun</u>	
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) <u>BRONCHOPNEUMONIA AND PULMONARY INSUFFICIENCY</u>					<u>5-6 YEARS</u>
DUE TO (b) <u>CYSTIC EMPHYSEMA, SEVERE, WITH COR PULMONALE</u>					<u>6 YEARS</u>
DUE TO (c) <u>527.1</u>					
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 checked="" 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.)			
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 <u>NOV 28, 1940</u> to <u>JUNE 5, 1960</u> and last saw her/him alive on <u>JUNE 5, 1960</u> Death occurred at <u>1:55 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C. Demillion, M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>6/16/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6/8/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington Cemetery</u>	23d. LOCATION (City, town, or county) <u>East St. Louis, Ill.</u>		
24. FUNERAL DIRECTOR <u>Marshall Fun Home-E. St. Louis, Ill.</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 8 1960</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2216

STATEMENT BY LICENSED EMBALMER

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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 Shirley M. Roberts

Licensed Embalmer No. 4479

P. O. Address 2205 Missouri
East St. Louis

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.