

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

60-021477

REGISTRATION DISTRICT 318 Primary Registration District 1003 REGISTRAR'S NO. 5550 STATE FILE NUMBER

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 4 Weeks | c. CITY OR TOWN East St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2419 Kansas Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last MATTIE NMN SCAGGS | 4. DATE OF DEATH Month Day Year MAY 25 1960 |
|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|----------------|
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/20/1891 | 9. AGE (last birthday) 69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-------------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|----------------|

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Woodstock, Tenn. | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
|---|--|---|--|

| | | |
|--|--|--|
| 13a. FATHER'S NAME WILLIAM TIMMONS | 13b. MOTHER'S MAIDEN NAME MATTIE (UNKNOWN) | 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 Edward Scaggs, 2419 Kansas Ave. |
|---|---|---|

| | |
|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED MULTIPLE MYELOMA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS |
|---|--|

| | |
|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) 203x | 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 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 AUGUST 19, 1959 to MAY 25, 1960 and last saw her/him alive on MAY 25, 1960 Death occurred at 9:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. |
|---|

| | | |
|--|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) <i>E. Vermillion, M.D.</i> | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 5/26/60 |
|--|--|------------------------------------|

| | | | |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/29/60 | 23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memory - Booker Washington | 23d. LOCATION (City, town, or county) Centreville Township, Ill. |
|--|-----------------------------|---|--|

| | | | |
|--|--|--|--|
| 24. FUNERAL DIRECTOR <i>Marion's Office</i> | ADDRESS 2114 Missouri E. St. Louis | 25. DATE RECD. BY LOCAL REG. MAY 28 1960 | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> |
|--|--|--|--|

BY AFFIDAVIT OF Funeral Director MEDICAL CERTIFICATION DOCUMENT

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 Francis Prokoff

Licensed Embalmer No. 4356

P. O. Address St. Louis, 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.

1961 7 NMP1