

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

=60-021944

FILED VS MAY 31 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1554 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)	
a. COUNTY <u>ST. LOUIS COUNTY</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) <u>MANCHESTER Mo.</u> OR TOWN Length of stay in lb <u>14 DAYS</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pine Crest Nursing Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Kinloch</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5701 So. Evergreen</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LUBA</u> Middle Last <u>Rise</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1865</u>	9. AGE (last birthday) <u>95 YRS.</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>Arlington, Tenn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>Will Rise</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>NONE</u>	17. INFORMANT <u>My A.D. Cherry</u> Address <u>5701 Evergreen</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arterio-sclerotic Cardiovascular Disease & Chronic Brain Syndrome</u>	
	DUE TO (c) <u>Brain Syndrome</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertensive Cardiovascular Disease</u>	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
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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"/> <u>None</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u>1400</u> Month, Day, Year <u>5-9-60</u> a.m. p.m.		

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 <u>St. Louis</u>	COUNTY <u>St. Louis</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>4-18-60</u> to <u>5-9-60</u> and last saw her/him alive on <u>5-3-60</u> Death occurred at <u>1400</u> on <u>5-9-60</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22. SIGNATURE (Degree or title) <u>Allen P. Kearney M.D.</u>	22b. ADDRESS <u>4308 E. Peters St. St. Louis Mo.</u>	22c. DATE SIGNED <u>5-10-60</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/16/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>
23d. LOCATION (City, town, or county) <u>Duikerley, Mo.</u>		23e. STATE <u>Mo.</u>

24. FUNERAL DIRECTOR <u>L.B. Keane</u> ADDRESS <u>1221 N. Howard</u>	25. DATE RECD. BY LOCAL REG. <u>5-12-60</u>	26. REGISTRAR'S SIGNATURE <u>J. M. ...</u>
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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 Charles J. [Signature]

Licensed Embalmer No. 475-5

P. O. Address 127 N. [Signature]

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.