

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 1 1960

-60-024932

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6369 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO		c. CITY OR TOWN ST. LOUIS, MO	
Length of stay in 1b 5yr		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MASONIC HOME HOSPITAL		d. STREET ADDRESS 5351 DELMAR (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Harrison J Saunders			4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>60</u>			
First	Middle		Last	Month	Day	

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Dec 23 1871	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
-----------------------	----------------------------------	---	--	-------------------------------------	--------------------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY Doctor	11. BIRTHPLACE (City and state or country) Chicago, Ill	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	---	--

13a. FATHER'S NAME THOMAS B. SAUNDERS	13b. MOTHER'S MAIDEN NAME MARY C. Unknown	14. NAME OF HUSBAND OR WIFE Frances W. Saunders
---	---	---

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. 498-09-2144A	17. INFORMANT Mr Lewis Robertson 5351 Delmar Blvd
--	--	---

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) Chronic Nephrosclerosis		unknown
DUE TO (b) Nephrosis		unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (c) Secondary Puerperal Poisoning		2 Weeks
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.)
---	---	--

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 2-25-55 to 6-22-60 and last saw ^{her}him alive on 6-21-60
Death occurred at 8/20 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Harold E. Walters, M.D. (Degree or title)	22b. ADDRESS 3720 Washington Ave.	22c. DATE SIGNED 6-23-60
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/24/60	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
--	-----------------------------	------------------------------------	---

24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd	25. DATE RECD. BY LOCAL REG. JUN 22 1960	26. REGISTRAR'S SIGNATURE Joan Smith, M.D.
--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

mfb

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 Joseph E. McCulloch
Licensed Embalmer No. 2400

P. O. Address 6175 P. O.

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.