

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

FILED VS JUL 1 1960

318 Primary Registration District No. 1003 Registrar's No. 6296

-60-025037

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 <b>ST. LOUIS, MO.</b>				Length of stay in 1b		c. CITY OR TOWN <b>St Louis</b>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.#1</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1418 A S Broadway</b>		
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle Last <b>URSICH</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>17</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/8/89</b>		
9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (City and state or country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY <b>U S</b>	
13a. FATHER'S NAME <b>Alois Krist</b>				13b. MOTHER'S MAIDEN NAME <b>Mary Katlech</b>		14. NAME OF HUSBAND OR WIFE <b>George (Deceased)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Frank Ursich 1418 A S Broadway</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b>							INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CONGESTIVE HEART FAILURE</b>							<b>3 weeks</b>	
DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>							<b>MANY YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.0</b>						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 Month, Day, Year 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.) <b>6/16/1960 5300</b>		20f. CITY, TOWN, OR LOCATION <b>6/17/1960</b>		COUNTY STATE <b>6/17/1960</b>		
21. I attended the deceased from <b>6/16/1960</b> to <b>6/17/1960</b> and last saw her/him alive on <b>6/17/1960</b> Death occurred at <b>3:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>John M. Tierney MD</b>				22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>6/17/1960</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>6/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St Louis County Mo</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Moydell Funeral Home 1926 Allen</b>				25. DATE RECD. BY LOCAL REG. <b>JUN 20 1960</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

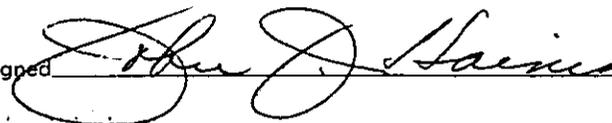
BY AFFIDAVIT OF

**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



Licensed Embalmer No. 4108

P. O. Address St. Louis, Mo.

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.