

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-027550

STATE FILE NUMBER

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 134

1. PLACE OF DEATH a. COUNTY <u>Lin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Marceline</u>		Length of stay in 1b OR TOWN <u>2 hrs.</u>		c. CITY OR TOWN <u>East Aton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>402 E Main St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Isabel</u> Last <u>ARNOLD</u>				4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</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>9/9/1917</u>	9. AGE (last birthday) <u>42</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Olin-Mathieson</u>		11. BIRTHPLACE (City and state or country) <u>Jonesboro, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Hoover</u>			13b. MOTHER'S MAIDEN NAME <u>Nora Ann Pence</u>		14. NAME OF HUSBAND OR WIFE <u>Aaron</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 <u></u> Address <u></u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia - Accutator of Brain</u> DUE TO (b) <u>Severe Head Injury -</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. <u>Severe Contusion chest, 1st rib radiast</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		
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.) <u>Auto Accident which occurred</u>			
20c. TIME OF INJURY Hour <u>5:50</u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u>7-2-60</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway #36 west of New Cambria</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>New Cambria 061 Macon MO</u>	
21. I attended the deceased from <u>7-2-60</u> and last saw her live on <u>7-2-60</u> Death occurred at <u>8:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>[Signature]</u>			22b. ADDRESS <u>Marceline MO</u>		22c. DATE SIGNED <u>7-3-60</u>		
23a. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>7/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Mem. Park</u>		23d. LOCATION (City, town, or county) <u>Godfrey, Ill.</u>			
24. FUNERAL DIRECTOR <u>James McLaughlin Marceline MO</u>			25. DATE RECD. BY LOCAL REG. <u>7-3-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 8 1 1960

NOV 15 1961

NOV 14 1961

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 Gerald I Wadsworth

Licensed Embalmer No. 4122

P. O. Address Browning

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.