

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

-60-028584

FILED VS. JUL 22 1960

318

Primary Registration District No. **1003**

Registrar's No. **6671**

STATE FILE NUMBER

ENDED

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| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Fayette | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | c. CITY OR TOWN Brownstown | |
| Length of stay in 1b 11 days | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's | | d. STREET ADDRESS (If outside, give location) R. R. 1 | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) Larry Eugene McCannack | | | 4. DATE OF DEATH Month 6 Day 30 Year 60 | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | |
| 8. DATE OF BIRTH 4-7-45 | | 9. AGE (last birthday) 15 years | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (City and state or country) Brownstown Illinois | | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME McCannack Forest | | 13b. MOTHER'S MAIDEN NAME Sidwell Marjorie | | |
| 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. none | | |
| 17. INFORMANT Mary Ritter | | Address 500 s Kingshighway | | | | |

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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) Respiratory and cardiac arrest | | | |
| DUE TO (b) Subarachnoid, subdural hemorrhage | | | |
| DUE TO (c) Extension head injury caused by auto. accident | | | 815.426 |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture left femur, left tibia, tibia, 2 ribcage fractures | | 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 checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT <input checked="" 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.) Pt. riding motorcycle when struck by an automobile | |
| 20c. TIME OF INJURY Hour a.m. p.m. 7:30 p.m. | | Month, Day, Year 6-19-60 | | Anatomical location Anatomical location by Dr. Clyde Austin of Brownstown, Ill. | |
| 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.) On a canopy road 71 | | 20f. CITY, TOWN, OR LOCATION Brownstown - Fayette Illinois | |
| 21. I attended the deceased from 6-19-60 to 6-30-60 and last saw her alive on 6-30-60 | | Death occurred at 8:45 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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| 22a. SIGNATURE (Degree or title) Frederick D. Johnson MD | | 22b. ADDRESS 500 S. Kingshighway | | 22c. DATE SIGNED 6-20-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 7-1-60 | | 23c. NAME OF CEMETERY OR CREMATORY Forbis Cem. | |
| 23d. LOCATION (City, town, or county) (State) Brownstown Fayette Ill. | | 24. FUNERAL DIRECTOR CLAGBETT | | 25. DATE RECD. BY LOCAL REG. JUL 1 1960 | |
| 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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 Frank Proloff

Licensed Embalmer No. 4350

P. O. Address St. Louis,

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.