

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 16 1960

60-031097

STATE FILE NUMBER

Registration District No. 162 Primary Registration District No. 5594 Registrar's No. 88

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Royal-Prinace</u>	Length of stay in 1b <u>5MO-13DAYS</u>	c. CITY OR TOWN <u>U. CITY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp Infirmary</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7329 LINDELL</u>

3. NAME OF DECEASED (Type or print) First <u>MALVERN</u> Middle <u>F.</u> Last <u>LAWRENSON</u>			4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>9/21/1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>RETIRED ATTORNEY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BELLS TELEPHONE</u>	11. BIRTHPLACE (City and state or country) <u>New London Conn.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	

13a. FATHER'S NAME <u>John LAWRENSON</u>	13b. MOTHER'S MAIDEN NAME <u>MARY MAHER</u>	14. NAME OF HUSBAND OR WIFE <u>LORETTA GREENS</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>WORLD WAR I</u>	16. SOCIAL SECURITY NO. <u>488-10-4725</u>	17. INFORMANT <u>Bro. Rah St. Joseph's Hosp Infirmary</u>

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Brain Syndrome</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"/>	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.)
		20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2-20-60 to 8-3-60 and last saw him alive on 7-28-60.
Death occurred at 10:00 am 8/3/60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Patrick G. Hogan</u> (Degree title)	22b. ADDRESS <u>2623 Telegraph Lemay</u>	22c. DATE SIGNED <u>8/3/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>AUG. 5, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEM.</u>
24. FUNERAL DIRECTOR <u>KRIEGSHAUSER 9450 OLIVE ST. RD.</u>		25. DATE RECD. BY LOCAL REG. <u>8-5-60</u>
26. REGISTRAR'S SIGNATURE <u>Robert G. Bauer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 17 1960

AUG 19 1960

SEP 8 1960

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 R. H. Stovens

Licensed Embalmer No. 4007

P. O. Address _____

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.