

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

FILED VS AUG 30 1960

60-031155  
STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3093 Registrar's No. 123

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in 1b <u>4 days</u>		c. CITY OR TOWN <u>Lebanon</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hospital</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route #3</u>
3. NAME OF DECEASED (Type or print) First <u>Alvena</u> Middle <u>Rae</u> Last <u>Raef</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</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>4-8-1880</u>	9. AGE (last birthday) <u>80</u>	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) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housework</u>		11. BIRTHPLACE (City and state or country) <u>Laclede Co.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>		13a. FATHER'S NAME <u>Gustofus Carlson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ross</u>	
14. NAME OF HUSBAND OR WIFE <u>Daniel Raef</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>none</u>	
17. INFORMANT <u>Gus Raef - Lebanon, Mo</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>Cerebral Hemorrhage (Left)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</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)		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 <u>April 22-1947</u> to <u>16 Aug 60</u> and last saw her alive on <u>16 Aug 60</u> Death occurred at <u>3.05 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Paul A. Jenkins MD</u>			22b. ADDRESS <u>Lebanon Mo</u>		22c. DATE SIGNED <u>18 Aug 60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-20-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon, City</u>		23d. LOCATION (City, town, or county) (State) <u>Lebanon, MO.</u>
24. FUNERAL DIRECTOR <u>A.R. Palmer</u>		ADDRESS <u>Lebanon, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-20-1960</u>	26. REGISTRAR'S SIGNATURE <u>Hella S. Day</u>

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 Allen Hooker

Licensed Embalmer No. 4333

P. O. Address Liberty

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.