

# FEDERAL BUREAU OF INVESTIGATION

## FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1960

=60-031783

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. \_\_\_\_\_ Registrar's No. 320

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Francois</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Doe Run</b> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Doe Run Mo.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Francois</b> c. CITY OR TOWN <b>Doe Run</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>Ellis</b> Last <b>Harris</b>	<b>4. DATE OF DEATH</b> Month <b>Aug</b> Day <b>13</b> Year <b>1960</b>
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<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 21, 1907</b>	<b>9. AGE (last birthday)</b> <b>53</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Doe Run, Missouri</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
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<b>13a. FATHER'S NAME</b> <b>Dallas Harris</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Lillie Langley</b>	<b>14. NAME OF HUSBAND OR WIFE</b> _____
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>498-10-4054</b>	<b>17. INFORMANT</b> Address <b>Mrs. Lester Swinford, Farmington, Mo.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis &amp; Hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 min 3 hrs
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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) _____	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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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____	<b>20d. INJURY-OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>
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<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE _____
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21. I attended the deceased from Aug 10, 1960 to Aug 13, 1960 and last saw <sup>her</sup> live on Aug 11, 1960  
 Death occurred at 12:45 am on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>Lester Swinford</u>	<b>22b. ADDRESS</b> <u>Farmington Mo</u>	<b>22c. DATE SIGNED</b> <u>8/14/60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>8-15-1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>	<b>23d. LOCATION (City, town, or county)</b> <b>Esther, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>R. Caldwell &amp; Sons Flat River, Mo</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>Aug 15, 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Esther Redloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT MEDICAL CERTIFICATION

**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 Donald Dale Caldwell

Licensed Embalmer No. 5095

P. O. Address Flat River, Va.

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.