

FEDERAL BUREAU OF INVESTIGATION  
 DEPARTMENT OF JUSTICE  
 NATIONAL CENTER FOR HEALTH STATISTICS  
 NATIONAL BUREAU OF VITAL STATISTICS  
 FEDERAL BUREAU OF INVESTIGATION

FILED VS. SEP 14 1960

318

Primary Registration District No. 1003

Registrar's No.

8684-60-031996  
 STATE FILE NUMBER

|   |   |   |   |   |   |   |  |  |
|---|---|---|---|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo</b> b. COUNTY |   |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. Louis</b>   |   | Length of stay in 1b  |   | c. CITY OR TOWN <b>ST. Louis</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>LUTHERAN HOSP.</b>  |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location)<br><b>2650 1/2 UTAH</b> |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOHN</b> Middle <b>RAYMOND</b> Last <b>CARROLL</b>  |   |   | 4. DATE OF DEATH<br>Month <b>SEPT</b> Day <b>4</b> Year <b>1960</b>   |   |   |   |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>SEPT 4, 1960</b>   |   | 9. AGE (last birthday)<br>IF UNDER 1 YEAR<br>Months Days Hours Min.       | IF UNDER 24 HR<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>ST. Louis, Mo</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>                            |  |  |
| 13a. FATHER'S NAME<br><b>JAMES F. CARROLL</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>MARY WATERS</b>   |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>-</b>                                   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, of unknown) (If yes, give war or dates of service)<br><b>No</b>   |   |   | 16. SOCIAL SECURITY NO.<br><b>No/No</b>   |   | 17. INFORMANT<br><b>JAMES CARROLL</b>                                 |   | Address<br><b>2650 1/2 UTAH</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>atelectasis Congestional</b><br>DUE TO (b) _____<br>DUE TO (c) <b>762.0</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |   |   |   |   |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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<br><b>ST. Louis</b>                      |   | COUNTY<br><b>Mo</b>  |  |
| 20f. CITY, TOWN, OR LOCATION<br><b>ST. Louis</b>  | COUNTY<br><b>Mo</b>   | STATE<br><b>Mo</b>  | 21. I attended the deceased from <b>150 am</b> to <b>2 27 am</b> and last saw <del>him</del> <sup>her</sup> alive on <b>9-4-60</b><br>Death occurred at <b>7</b> <b>2 27 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Hugh R. Smith M.D.</b>   |   |   | 22b. ADDRESS<br><b>100 N. Euclid</b>  |   |   | 22c. DATE SIGNED<br><b>9/6/60</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   | 23b. DATE<br><b>SEPT 6, 1960</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>RESURRECTION CEM</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>ST. Louis Co. Mo</b>  |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Thomas Kutis 2906 Groves</b>   |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>SEP 6 1960</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>Paul Smith M.D.</b>                   |   |  |  |

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 Thomas Cline

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Not Embalmed

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.