

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

7-60-032608

FILED VS AUG 26 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8223** STATE FILE NUMBER

DOCUMENT RECORDED BY ELECTION COMM. ST. LOUIS  
BY AFFIDAVIT OF funeral director MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4550 a Laclede Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4550 a Laclede Av.</b>
3. NAME OF DECEASED (Type or print) First <b>CLYDE</b> Middle <b>R.</b> Last <b>MICHAELREE</b>			4. DATE OF DEATH Month <b>8</b> Day <b>20</b> Year <b>60</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1908</b>	9. AGE (last birthday) <b>70 76</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Deputy Collector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Int. Rev. Ser.</b>	11. BIRTHPLACE (City and state or country) <b>Brazil, Ind.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Marshall Michaelree</b>		13b. MOTHER'S MAIDEN NAME <b>Gertrude Moore</b>		14. NAME OF HUSBAND OR WIFE <b>Margaret Sullivan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>494-07-1396</b>	17. INFORMANT Address <b>Margaret Michaelree 4550 a Laclede</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO (b) <b>Arteriosclerotic C.V.R. Dis.</b> DUE TO (c) <b>442x</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>- 5110</b>
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
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 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 <b>1946</b> to <b>Present</b> and last saw her alive on <b>Aug 6 1960</b> Death occurred at <b>356 A</b> m on the date stated above, and to the best of my knowledge from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Robert Michaelree M.D.</b>			22b. ADDRESS <b>2816 Leaton</b>		22c. DATE SIGNED <b>8/24/60</b>
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8/23/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection</b>		23d. LOCATION (City, town, or county) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>E. J. Schnur 3125 Lafayette Ave.</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>	

**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

*Joseph Vollemer*

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette

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.