

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**  
**JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-034085**

STATE FILE NUMBER

FILED VS. OCT 11 1960 53

3010

396

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

1. PLACE OF DEATH a. COUNTY <b>Cape Girardeau</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mississippi</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cape Girardeau</b>		Length of stay in 1b <b>1 Week</b>	c. CITY OR TOWN <b>Charleston</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Osteopathic Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>101 N. Elm St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agatha</b> Middle <b>McDaniel</b> Last <b>Martin</b>			4. DATE OF DEATH Month <b>10</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</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>5/22/17</b>	9. AGE (last birthday) <b>43</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>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Paragould, Ark.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James William McDaniel</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Clark</b>		14. NAME OF HUSBAND OR WIFE <b>Ray Martin</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Ray Martin, Charleston, Mo.</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>Pulmonary Infarction</b>					INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary Embolism</b>						
DUE TO (c) <b>Panhysterectomy</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 checked="" 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 checked="" 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>September 25, 1960</b> to <b>Oct. 3, 1960</b> and last saw her alive on <b>Oct. 3, 1960</b> Death occurred at <b>5:00 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Victor M. Bowe, D.O.</i>			22b. ADDRESS <i>Cape Girardeau, Mo.</i>		22c. DATE SIGNED <i>10-5-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/5/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) <b>Charleston, Mo.</b>		(State)
24. FUNERAL DIRECTOR <i>Gene Nunnelee</i> <b>The Nunnelee Funeral Chapel</b> Charleston, Mo.			25. DATE RECD. BY LOCAL REG. <b>10-7-60</b>		26. REGISTRAR'S SIGNATURE <i>Drene Kasten</i>	

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

*John D. [Signature]*

Licensed Embalmer No. 3851

P. O. Address Charleston

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.