

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

-60-034127

FILED VS OCT 3 1960

STATE FILE NUMBER

Registration District No. 5-9 Primary Registration District No. 4097 Registrar's No. 169

1. PLACE OF DEATH a. COUNTY <u>CASS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CASS</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>HARRISONVILLE</u>	Length of stay in lb <u>3 Days</u>	c. CITY OR TOWN <u>HARRISONVILLE</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS (if outside, give location) <u>1000 MAIN</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>SHERMAN</u> Last <u>LUDLOW</u>	4. DATE OF DEATH Month <u>Sept</u> Day <u>23</u> Year <u>1960</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-1891</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK-DRIVER</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>CASS COUNTY, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>LEVIN LUDLOW</u>	13b. MOTHER'S MAIDEN NAME <u>MARY F. WARREN</u>	14. NAME OF HUSBAND OR WIFE <u>ZINA LUDLOW</u>
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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>489-22-5720</u>	17. INFORMANT <u>Mrs ZINA LUDLOW HARRISONVILLE, MO</u> Address <u>1000 MAIN</u>
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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 - MASSIVE -</u> DUE TO (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>ACUTE INTERSTITIAL NEPHROSIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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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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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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
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21. I attended the deceased from SEPT. 20 1960 to SEPT-23-60 and last saw him alive on 9-23-1960  
 Death occurred at 01:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>David Long M.D.</u> (Degree or title)	22b. ADDRESS <u>Harrisonville, MO</u>	22c. DATE SIGNED <u>9-24-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-25-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WILLS Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Peculiar, Missouri</u>
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24. FUNERAL DIRECTOR <u>ATKINSON-DICKY</u>	ADDRESS <u>HARRISONVILLE, MO</u>	25. DATE RECD. BY LOCAL REG. <u>SEPT. 24-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Ray Sebee</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 11 1960

STATEMENT BY LICENSED EMBALMER

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Robert W. Robinson

Licensed Embalmer No. 4902

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

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