

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

-60-036221

FILED VS SEP 21 1960

318

1003

9127

STATE FILE NUMBER

INDEXED

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		Length of stay in 1b	c. CITY OR TOWN
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION		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"/>

3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year		
5. SEX			6. COLOR OR RACE		
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
9. AGE (last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
11. BIRTHPLACE (City and state or country)			12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a)			10 yrs		
DUE TO (b)			20 yrs		
DUE TO (c)			420.0		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.		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 <u>Feb 18, 1943</u> to <u>Sept 14, 1960</u> and last saw her <sup>her</sup> alive on <u>Sept 13, 1960</u> Death occurred at <u>8:10 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					

22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION (City, town, or county)		(State)		24. FUNERAL DIRECTOR ADDRESS	
25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE		27. ADDRESS	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Alexander & Sons 6175 Delmar Blvd SEP 15 1960 Carl Smith, M.D.

Dr. John Horner

114 No. Taylor

Je. 3-8600

1 P.M.

**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 NO EMBALMING, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*jos. E. Mculloch*

Licensed Embalmer No. 276

P. O. Address 6175

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.