

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
 FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE

**FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE**

FILED VS OCT 3 1 1960

-60-038092

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1079

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Jackson						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b		c. CITY OR TOWN Jackson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1107 Union		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle T. Last Torwick				4. DATE OF DEATH Month October Day 25 , Year 1960						
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 22 Sept. 1902	9. AGE (last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10b. KIND OF BUSINESS OR INDUSTRY Physician		11. BIRTHPLACE (City and state or country) Minnesota		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME E. E. Torwick			13b. MOTHER'S MAIDEN NAME Matilda Hendrickson			14. NAME OF HUSBAND OR WIFE Winfred Torwick				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Winfred Torwick (Wife) Address 1107 Union St. Jackson, Michigan				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of Myocardium DUE TO (b) Atherosclerotic Heart Disease with DUE TO (c) Coronary Thrombosis - Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
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 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 Month, Day, Year 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 10/20/60 to 10/25/60 and last saw him ^{her} alive on 10/25/60 Death occurred at 1:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <i>Ed R. Turner MD</i>				22b. ADDRESS 600 S. Glenstone Springfield, Missouri				22c. DATE SIGNED 10-27-60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal - Burial		23b. DATE 10-26-60	23c. NAME OF CEMETERY OR CREMATORY VOLGA CEMETERY		23d. LOCATION (City, town, or county) (State) VOLGA, SOUTH DAKOTA					
24. FUNERAL DIRECTOR Klingner Mortuary ADDRESS Springfield, Mo.				25. DATE RECD. BY LOCAL REG. 10-28-60		26. REGISTRAR'S SIGNATURE <i>Effie B. Mellon</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

jhc

(Licensed Embalmer's Statement on Reverse Side)

0961 1 AON

DEC 1 1960

DEC 12 1960

DEC 1 1960

0961 3 AON SA

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Mal Phode

Licensed Embalmer No. 407

P. O. Address *Spring*

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