

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

FILED VS NOV 14 1960

-60-040771

Registration District No. 947 Primary Registration District No. \_\_\_\_\_ Registrar's No. 30 STATE FILE NUMBER \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Stone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Blue Eye, Missouri</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Blue Eye, Missouri</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1 Mile East Blue Eye,</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1 Mile East</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ruth Magdalena</u> Middle <u>Jones</u> Last _____	4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1960</u>
---	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-6-1891</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
----------------------	-------------------------------	--	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Denver, Colorado</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	--	--

13a. FATHER'S NAME <u>Joseph C. Grishabes</u>	13b. MOTHER'S MAIDEN NAME <u>Mabel Foreman</u>	14. NAME OF HUSBAND OR WIFE <u>James Riley Jones</u>
---	--	--

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>No</u>	17. INFORMANT Address <u>Basil Jones Blue Eye, Missouri</u>
--	-----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Lobar</u> DUE TO (c) <u>Organic Heart &amp; Arterial debility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
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 10-21-60 to 10-21-60 and last saw her/him alive on 10-21-60  
 Death occurred at \_\_\_\_\_ o'clock on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>A. L. Carter M.D.</u>	22b. ADDRESS <u>Berryville Ark</u>	22c. DATE SIGNED <u>11-2-60</u>
---	------------------------------------	---------------------------------

23a. CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-24-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blue Eye Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Carroll Arkansas</u>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <u>Nelson Funeral Home - Berryville</u>	25. DATE RECD. BY LOCAL REG. <u>Nov 2 1960</u>	26. REGISTRAR'S SIGNATURE _____
--	--	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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 Charles M. Nelson

Licensed Embalmer No. 5002

P. O. Address Beverly, A

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.

