

**FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-040830**

FILED VS OCT 25 1960 360

6225 Registrar's No. 216

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 216

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Texas Co.</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township St. Hosp. # 3</u>		Length of stay in lb <u>2 months</u>	c. CITY OR TOWN <u>Cabool</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			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>F.</u> Last <u>Cluck</u>			4. DATE OF DEATH Month <u>10</u> - Day <u>16</u> - Year <u>1960</u>		
5. SEX <u>Male</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>3-15-1880</u>	9. AGE (last birthday) <u>80</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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Elbert Cluck</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</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>Unknown</u>	17. INFORMANT <u>Records of</u> Address <u>St. Hosp. # 3, Nevada, Missouri</u>		
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) <u>Coronary Vessel Disease</u>					<u>Years</u>
DUE TO (b) <u>Atheromatous Sclerosis</u>					<u>Years</u>
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Associated with Circulatory Disturbance with Cerebral Arteriosclerosis with Psychotic Reaction.</u>					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 _____ 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 <u>8-29-60</u> to <u>10-16-60</u> and last saw <sup>Xer</sup> him alive on <u>10-16-60</u> Death occurred at <u>8:50 p.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. Elliott Gentry</u> (Degree or title)			22b. ADDRESS <u>St. Hosp. # 3, Nevada, Mo.</u>		22c. DATE SIGNED <u>10-17-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/17/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Cabool, Missouri</u>	
24. FUNERAL DIRECTOR <u>Elliott Gentry, F. H. Cabool, Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>10-18-1960</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Gentry</u>	

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 Lloyd C. McCall

Licensed Embalmer No. 4853

P. O. Address Florida, Fla.

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.