

FEDERAL BUREAU OF INVESTIGATION  
 U.S. DEPARTMENT OF JUSTICE  
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FILED VS JAN 16 1967

43

Primary Registration District No. 3007

Registrar's No. 685

60-045286

STATE FILE NUMBER

ENDED

|                                                                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                          |                                                                                                                                                                      |                                                                                       |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Butler</b>                                                                                                                                                                                                                                                                       |                                        |                                                                                                                                                             |                                                                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> . COUNTY <b>Butler</b> |                                                                                                                                                                      |                                                                                       |       |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>                                                                                                                                                                                                                              |                                        | Length of stay in 1b <b>89 Yrs.</b>                                                                                                                         |                                                                                      | c. CITY OR TOWN <b>Poplar Bluff</b>                                                                                                      |                                                                                                                                                                      | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |       |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>At Home</b>                                                                                                                                                                                                                         |                                        |                                                                                                                                                             | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <b>1318 Spring St.</b>                                                                     |                                                                                                                                                                      | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Nancy</b> Middle <b>E.</b> Last <b>Sims</b>                                                                                                                                                                                                                        |                                        |                                                                                                                                                             |                                                                                      | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>28</b> Year <b>1960</b>                                                                     |                                                                                                                                                                      |                                                                                       |       |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                                                                                            | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/11/1870</b>                                                 | 9. AGE (last birthday)<br><b>90</b>                                                                                                      | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>17</b>                                                                                                                    | IF UNDER 24 HR<br>Hours <b></b> Min. <b></b>                                          |       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                    |                                        | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                                                                                                            |                                                                                      | 11. BIRTHPLACE (City and state or country)<br><b>Ohio</b>                                                                                |                                                                                                                                                                      | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b>                                        |       |
| 13a. FATHER'S NAME<br><b>John P. Montgomery</b>                                                                                                                                                                                                                                                                    |                                        |                                                                                                                                                             | 13b. MOTHER'S MAIDEN NAME<br><b>Rachel Woods</b>                                     |                                                                                                                                          | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b>                                                                                                                       |                                                                                       |       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                                                                                              |                                        |                                                                                                                                                             | 16. SOCIAL SECURITY NO.                                                              | 17. INFORMANT Address<br><b>Mrs. Fred Hargrove, Poplar Bluff, Mo</b>                                                                     |                                                                                                                                                                      |                                                                                       |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u><br>DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                          |                                                                                                                                                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 yrs</b><br><b>25 yrs</b>                    |       |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                                                                       |       |
| 19. WAS AUTOPSY PERFORMED?<br>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.)                                             |                                                                                                                                                                      |                                                                                       |       |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>p.m. _____                                                                                                                                                                                                                                                      |                                        | Month, Day, Year _____                                                                                                                                      |                                                                                      |                                                                                                                                          |                                                                                                                                                                      |                                                                                       |       |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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>Dec 1955</u> to <u>Nov 28, 1960</u> and last saw her alive on <u>26 Dec. 60</u><br>Death occurred at <u>7:30 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                      |                                        |                                                                                                                                                             |                                                                                      |                                                                                                                                          |                                                                                                                                                                      |                                                                                       |       |
| 22a. SIGNATURE (Degree or title)<br><i>Cyril G. Post M.D.</i>                                                                                                                                                                                                                                                      |                                        |                                                                                                                                                             |                                                                                      | 22b. ADDRESS<br><i>Poplar Bluff, Mo</i>                                                                                                  |                                                                                                                                                                      | 22c. DATE SIGNED<br><i>30 Dec 60</i>                                                  |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>                                                                                                                                                                                                                                                         | 23b. DATE<br><b>Dec. 1, 1960</b>       | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>                                                                                                       |                                                                                      | 23d. LOCATION (City, town, or county)<br><b>Poplar Bluff, Missouri</b>                                                                   |                                                                                                                                                                      | (State)                                                                               |       |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Frank-Cotrell Chapel, Poplar Bluff</b>                                                                                                                                                                                                                                          |                                        |                                                                                                                                                             | 25. DATE RECD BY LOCAL REG.<br><b>Mo. 1/2/60</b>                                     |                                                                                                                                          | 26. REGISTRAR'S SIGNATURE<br><i>R. Muettee</i>                                                                                                                       |                                                                                       |       |

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Edgar W. Taylor*

Licensed Embalmer No. *339*

P. O. Address *Poplar*

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.