

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

-60-048299

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3616

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS COUNTY</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PINE LAWN</u> | | Length of stay in 1b _____ | c. CITY OR TOWN <u>Unk</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SHAMROCK REST HOME</u> | | 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 type="checkbox"/> |

| | | | | | |
|--|-------------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle _____ Last <u>MALONEY</u> | | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>9th</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>MAR 27, 1873</u> | 9. AGE (last birthday) <u>87</u> | IF UNDER 1 YEAR Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) <u>unk</u> | 12. CITIZEN OF WHAT COUNTRY _____ | |
| 13a. FATHER'S NAME <u>unk</u> | | 13b. MOTHER'S MAIDEN NAME <u>unk</u> | | 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 <u>SHAMROCK NURS. HOME</u> Address _____ | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |

| | | | |
|---|--|--|--|
| 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 Sept 19, 1952 to Dec 9, 1960 and last saw him alive on DEC 5, 1960
Death occurred at 5:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|---|---------------------------|--|---|----------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Lewis Littmann MD</u> | | 22b. ADDRESS <u>8231 Clayton Rd (17)</u> | | 22c. DATE SIGNED <u>12/10/60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Anatomical</u> | 23b. DATE <u>12-15-60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Rowland-Aker Mortuary Service</u> <u>4104 Manchester Ave.</u> <u>St. Louis 10, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-15-60</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</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 me
or by Anatomical, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Mary Kearney
Licensed Embalmer No. _____

P. O. Address _____

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.