

FEDERAL BUREAU OF INVESTIGATION

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-48992

STATE FILE NUMBER

OF PUBLIC HEALTH AND WELFARE

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED AUG 23 1961

1. PLACE OF DEATH a. COUNTY Butler b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Poplar Bluff Hospital Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler c. CITY OR TOWN Qulin Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Route #1 Box 288B Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last GRACE AUSTIN			4. DATE OF DEATH Month Day Year August 29 1960				
5. SEX Female	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 7-17-	9. AGE (last birthday) 50	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) USA 12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Robert Austin			
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. Unknown		17. INFORMANT Address Poplar Bluff Hospital Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic duodenal ulcer with chronic hemorrhage therefrom. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH		
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 checked="" 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. attended the deceased from Aug. 19, 1960 to August 29, 1960 and last saw her XX alive on August 29, 1960 Death occurred at 2:15 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Degree or title) Harold O. Schmickler M.D.			22b. ADDRESS Poplar Bluff, Missouri		22c. DATE SIGNED 7-28-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/31/1960	23c. NAME OF CEMETERY OR CREMATORY Qulin		23d. LOCATION (City, town, or county) (State) Qulin, Missouri		
24. FUNERAL DIRECTOR ADDRESS McDaniel Funeral Home, Kennett, Mo.			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE Harold O. Schmickler M.D.		

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

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.