

FEDERAL BUREAU OF INVESTIGATION  
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031929

FILED VS. SEP 28 1959

115-116

Primary Registration District No. 3020

Registrar's No. 201

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Franklin</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis (City)</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Francis Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4138a Iowa St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Connie</b> Middle <b>Marie</b> Last <b>Treese</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>12</b> Year <b>1959</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> <b>Infant</b>		8. DATE OF BIRTH <b>9/5/59</b>		9. AGE (last birthday) <b>0</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>7</b>		IF UNDER 24 HR Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (City and state or country) <b>Dr. Crawford's Office Sullivan, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>George Wm. Treese</b>				13b. MOTHER'S MAIDEN NAME <b>Judith Yvonne Thoma</b>				14. NAME OF HUSBAND OR WIFE <b>---</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>St. Francis Hosp. Records, Washington, Mo.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - 26 wks. gest.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
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) <b>o</b>								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 <b>Sept. 6, 1959</b> to <b>Sept. 12, 1959</b> and last saw <b>her</b> alive on <b>Sept. 11, 1959</b> Death occurred at <b>4:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>Robert W. Crawford M.D.</b>				22b. ADDRESS <b>Sullivan, Missouri</b>				22c. DATE SIGNED <b>Sept 13 1959</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9/12/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kinda Cemetery</b>		23d. LOCATION (City, town, or county) <b>Cuba, Missouri</b>		(State)					
24. FUNERAL DIRECTOR <b>J.P.A. Shanth</b>				ADDRESS <b>Cuba, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9/19/59</b>		26. REGISTRAR'S SIGNATURE <b>J.P. Sidman</b>					

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

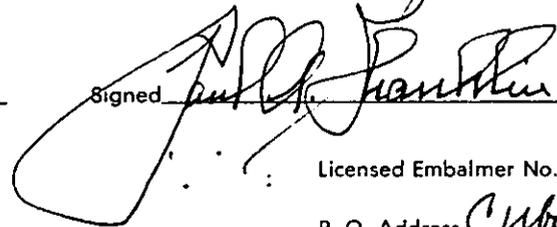
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3472

P. O. Address. Cuba, Mo.

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.