

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

**59-033674**

**FILED VS OCT 5 1959**

**2 8696**

STATE FILE NUMBER

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

UNRECORDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b <b>1 day</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Children's Hospital</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jefferson</b> c. CITY OR TOWN <b>Hillsboro</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>R. R. #2</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Peggy</b> Middle <b>Lee</b> Last <b>Clinton</b>				<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>21</b> Year <b>1959</b>					
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/5/59</b>		<b>9. AGE</b> (last birthday) <b>16</b> IF UNDER 1 YEAR: Months _____ Days <b>16</b> Hours _____ Min. _____ IF UNDER 24 HR: _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b>			<b>11. BIRTHPLACE</b> (City and state or country) <b>Festus, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A</b>	
<b>13a. FATHER'S NAME</b> <b>Gerald Louis Clinton</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Emma Britton</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>none</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____			<b>16. SOCIAL SECURITY NO.</b> <b>none</b>			<b>17. INFORMANT</b> <b>Helen Nesselin-500 S. Kingshighway</b> Address _____			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Circulatory collapse</b> DUE TO (c) <b>Bilateral Bunchapneumonia</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Microcephaly</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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> _____ COUNTY _____ STATE _____			
<b>21. I attended the deceased from</b> <b>9/20/59</b> to <b>9/21/59</b> and last saw her/him alive on <b>9/21/59</b> Death occurred at <b>9:56a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
<b>22a. SIGNATURE</b> <b>Frederick D. Peterson M.D.</b> (Degree or title)					<b>22b. ADDRESS</b> <b>500 S. Kingshighway</b>		<b>22c. DATE SIGNED</b> <b>9/21/59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>		<b>23b. DATE</b> <b>9/21/1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Odd Fellows Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) <b>Bismarck, Missouri</b> (State) _____				
<b>24. FUNERAL DIRECTOR</b> <b>McLAUGHLIN'S, 2301 Lafayette Ave.</b> ADDRESS _____				<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 21 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith, M.D.</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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*James P. Chapman*  
\_\_\_\_\_  
Licensed Embalmer No. 455

P. O. Address H. Lewis

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.