

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE

59-036160

FILED VS. NOV 10 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5072

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 56 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wheatley Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1211 E. 16th. St.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Ewing				4. DATE OF DEATH Month Day Year Oct. 19, 1959					
5. SEX male	6. COLOR OR RACE negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-25-1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hod carrier			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Holden, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME James Ewing			13b. MOTHER'S MAIDEN NAME Francis Fisher			14. NAME OF HUSBAND OR WIFE Anna Ewing			
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. 495-03-3358A.		17. INFORMANT Address Anna Ewing 1211 E. 16th. St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive failure							INTERVAL BETWEEN ONSET AND DEATH 19 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) hypertensive type heart disease									
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 Oct. 1, 1959 to Oct. 19 -59 and last saw her alive on Oct. 19, 1959 Death occurred at 10:00 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>W. C. Turner M.D.</i>				22b. ADDRESS 1433 E. 19th. St.			22c. DATE SIGNED 10-21-59		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 10-24-59	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn			23d. LOCATION (City, town, or county) (State) Kansas City, Mo.			
24. FUNERAL DIRECTOR ADDRESS Manlove-Williams 1729 Lydia			25. DATE RECD. BY LOCAL REG. 10-22-59		26. REGISTRAR'S SIGNATURE <i>Neve Minshall</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
W. C. Turner

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.