

FEDERAL BUREAU OF INVESTIGATION UNITED STATES DEPARTMENT OF JUSTICE

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1959

58 59-037086

STATE FILE NUMBER

Registration District No. 272 Primary Registration District No. 5907 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Permeset</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Steele</u> Length of stay in 1b <u>Life</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cook's Bay</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Permeset</u> c. CITY OR TOWN <u>Steele</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Road 2</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie Washington</u>				4. DATE OF DEATH Month Day Year <u>10-30-59</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-18-59</u>		9. AGE (last birthday) IF UNDER 1 YEAR Months <u>3</u> Days <u>12</u> IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>chick</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Steele MO</u>			11. BIRTHPLACE (City and state or country) <u>Steele MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>JW Washington</u>				13b. MOTHER'S MAIDEN NAME <u>Alice Jones</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) <u>No</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>JW Washington Steele MO</u>					
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>Pneumonia</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 INTERVAL BETWEEN ONSET AND DEATH <u>10-28-59</u>											
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 <u>10-29-59</u> to <u>10-29-59</u> and last saw ^{her} _{him} alive on <u>10-29-59</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>M. J. Davis MD</u>				22b. ADDRESS <u>Steele MO</u>				22c. DATE SIGNED <u>10-30-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-30-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holly Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Steele MO</u>					
24. FUNERAL DIRECTOR ADDRESS <u>Essment Funeral Home Steele MO</u>				25. DATE RECD. BY LOCAL REG. <u>11-2-59</u>		26. REGISTRAR'S SIGNATURE <u>J. H. O. [Signature]</u>					

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

