

FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
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FILED VS NOV 3 1959

59-037380

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STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 15 yrs		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3936 Lafayette Avenue			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3936 Lafayette Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle CHARLES Last ANGOVE				4. DATE OF DEATH Month Oct. Day 18, Year 1959					
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8/14/1874	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired machinist helper			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and state or country) Bonne Terre, Missouri		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME James Angove			13b. MOTHER'S MAIDEN NAME Mary Annear			14. NAME OF HUSBAND OR WIFE Margarette Hart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 702-16-6705		17. INFORMANT Address Mr. Alden Angove, 3936 Lafayette Avenue				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Conditions if any which gave rise to above (a), state the underlying cause last. DUE TO (b) Arterio-sclerotic Heart Disease DUE TO (c) 420.0 INTERVAL BETWEEN ONSET AND DEATH Several hours Several years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Duodenal Ulcer						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 checked="" 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 June 26, 1959 Sept. 3, 1959 and last saw him alive on Sept. 3, 1959 Death occurred at 2:00 P. M. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Benjamin H. Thacker, Jr. P.				22b. ADDRESS Mo. Pacific Hospital - St. Louis			22c. DATE SIGNED Oct. 17, 1959		
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Oct. 21, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Francois Memorial Park		23d. LOCATION (City, town, or county) Bonne Terre, Missouri		(State)		
24. FUNERAL DIRECTOR ADDRESS BEIDERWIEDEN F.H. INC. 1936 St. Louis Ave.				25. DATE RECD. BY LOCAL REG. OCT 20 '59		26. REGISTRAR'S SIGNATURE Loal Smith, M.D. <i>mdc.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Benjamin Charles

Mo. Pac. Hospital

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 _____

Homer H. [Signature]

Licensed Embalmer No. _____

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P. O. Address _____

St. Louis

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.