

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 12 1959

59-037617

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210040**

UNRECORDED

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Jersey Co			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI			Length of stay in 1b 4 Days		c. CITY OR TOWN GRAFTON R.F.D.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) OTTER Creek Twnshp.	
3. NAME OF DECEASED (Type or print) First LINNIE Middle ANNETTE Last GETTINGS			4. DATE OF DEATH Month OCTOBER Day 30 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-19-1912	9. AGE (last birthday) 47	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (City and state or country) EDDYVILLE, Ky.		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME MARSHALL Weeks			13b. MOTHER'S MAIDEN NAME MARY MURRAY		14. NAME OF HUSBAND OR WIFE JAMES		
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. None		17. INFORMANT James Gettings Address A. 4. D. Grafton Ill.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT							1 WEEK
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS							SEVERAL YRS
DUE TO (c) HYPERTENSION							16 YEARS
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. 27, 1959 to OCT. 30, 1959 and last saw her/him alive on OCT. 30, 1959 Death occurred at 1:35 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Ed. Vermillion, M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 10/31/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY DAK GROVE Cem.		23d. LOCATION (City, town, or county) (State) Jerseyville ILL.	
24. FUNERAL DIRECTOR JACOBY BROS.		ADDRESS Jerseyville, Ill.		25. DATE RECD. BY LOCAL REG. NOV 2 1959		26. REGISTRAR'S SIGNATURE Loan Smith, M.D. S.P.	

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 Frank Proloff

Licensed Embalmer No. 4356

P. O. Address St Louis, 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.