

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1959

59-038071

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-9689**

RECEIVED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS 1019 N. 7th St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Kate Middle _____ Last Scott			4. DATE OF DEATH Month 10 Day 13 Year 59			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-15-1876	9. AGE (last birthday) 83	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) at home	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Ben Childs	13b. MOTHER'S MAIDEN NAME Mary Hill	14. NAME OF HUSBAND OR WIFE -
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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. no	17. INFORMANT Address Irma Scott 1019 N. 7th St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis and Hydronephrosis DUE TO (b) Obstructive Uropathy DUE TO (c) Epidermoid Carcinoma of Cervix		INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171x	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
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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.) _____
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20c. TIME OF INJURY Hour _____ a.m. / p.m. Month, Day, Year _____	_____
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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 _____
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21. I attended the deceased from **6-9-59** to **10-13-59** and last saw her ^{her} relative on **10-13-59**
 Death occurred at **4:00** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Samuel E. Harris, M.D.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 10/15/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Rowland Aker Mortuary Service	23b. DATE 10-31-59	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR 4104 Manchester Ave. St. Louis 10, Mo.	25. DATE RECD. BY LOCAL REG. OCT 22 1959	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MVB

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 Clarence Graham

Licensed Embalmer No. 4955

P. O. Address 122 NW 1st

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.