

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-038465

FILED VS NOV 2 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2854 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Saint Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Normandy	Length of stay in 1b 13 days	c. CITY OR TOWN Valley Park	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Normandy Osteopathic Hosp.		d. STREET ADDRESS Box 248	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First James Middle Morris Last Cottingham	4. DATE OF DEATH Month Oct. Day 25, Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-27-1905	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self-employed	10b. KIND OF BUSINESS OR INDUSTRY Physician	11. BIRTHPLACE (City and state or country) Indiana	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME William W. Cottingham	13b. MOTHER'S MAIDEN NAME Jessie McDowell	14. NAME OF HUSBAND OR WIFE Ailene Cottingham
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15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 490-44-4090	17. INFORMANT Address Mrs. Ailene Cottingham-Box 248-Valley Park
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pulmonary Embolism		immediate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Bacterial Endocarditis		1 mth
	DUE TO (c) Unidentified pathogen	1 mth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus	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
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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.)
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20c. TIME OF INJURY _____ out _____ 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 9-21-59 to Oct. 25, 1959 and last saw her/him alive on Oct. 25, 1959
Death occurred at 4:27 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Albert H. Hoppe</i> DO	22b. ADDRESS 1917 N. Hanley Rd. St. Louis 14	22c. DATE SIGNED 10-26-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/28/59	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) Rolla, Missouri.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington	25. DATE RECD. BY LOCAL REG. 10-27-59	26. REGISTRAR'S SIGNATURE <i>John B. McFly M.D.</i>
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DOCUMENT

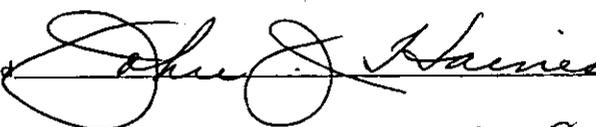
MEDICAL CERTIFICATION

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  _____

Licensed Embalmer No. 4108

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.