

FEDERAL BUREAU OF INVESTIGATION
 FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038482

FILED VS/NOV 16 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2961

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis County		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ellisville		Length of stay in 1b 44 yrs	c. CITY OR TOWN Ellisville Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunset Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 472 Ridge Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last IDRESS WALLACE FLOWER			4. DATE OF DEATH Month Day Year November 7 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 10/6/1878
9. AGE (last birthday) 81		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Fayette, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME James C. Wallace	
13b. MOTHER'S MAIDEN NAME Laura Watts		14. NAME OF HUSBAND OR WIFE William H. Flower	
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 Address Mrs. K.E. Blumenhorst 33 Marshall Pt.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident			INTERVAL BETWEEN ONSET AND DEATH approx 2 1/2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebro-arteriosclerosis			
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 checked="" 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 Month, Day, Year a.m. p.m.	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 November 3, 1959 to November 7, 1959 and last saw her alive on November 6, 1959 Death occurred at Ellisville, Mo. 5:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE George E. Smith M.D. (Degree or title)		22b. ADDRESS 1177 1/2 Manchester Road St. Louis 21, Mo.	22c. DATE SIGNED Nov. 7, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 9, 1959	23c. NAME OF CEMETERY OR CREMATORY Keytesville Cemetery	23d. LOCATION (City, town, or county) (State) Kettesville, Missouri
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons 6175 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. 11-7-59	26. REGISTRAR'S SIGNATURE John Murphy M.D.

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Jos. E. McCulloch

Licensed Embalmer No. 2760

P. O. Address 617 0111

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.