

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE
JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039250

FILED VS NOV 3 0 1959

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 83 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u>	Length of stay in 1b	c. CITY OR TOWN <u>Carrollton</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>207 W. Washington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. F. D. 5</u>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES FRANKLIN METCALF</u>			4. DATE OF DEATH Month Day Year <u>Nov. 25 1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-1881</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Chariton Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Metcalf</u>	13b. MOTHER'S MAIDEN NAME <u>Barbara Ann Gregory</u>	14. NAME OF HUSBAND OR WIFE <u>Ethel Gertrude Metcalf</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>500-40-4501</u>	17. INFORMANT <u>Mrs. J. F. Metcalf</u> Address <u>Carrollton, Mo.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction of abdominal aorta upon arterosclerosis - atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) <u>arterosclerosis - atherosclerosis</u>	
	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 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.)
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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Carrollton Mo</u>	COUNTY <u>Carroll Co.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from Oct 1 1959 to Nov 27 59 and last saw ^{her}him alive on Nov 24-59
 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Cecil Bales M.D.</u>	22b. ADDRESS <u>Carrollton Mo</u>	22c. DATE SIGNED <u>11-28-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Willis Chapel Cem.</u>	23d. LOCATION (City, town, or county) <u>Carroll Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Gibson Funeral Home, Carrollton Mo.</u>	ADDRESS <u>Carrollton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-28-59</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Calvert</u>
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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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton

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.