

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-041837

FILED VS NOV 3 0 1959

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **210272**

MAILED

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                   |  | Length of stay in 1b   | c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital-D.O.A.</b> |  | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>1655 S. Vandeventer</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

|  |                   |  |                |
|--|-------------------|--|----------------|
| 3. NAME OF DECEASED (Type or print)<br><b>BESSIE FORREST</b> | First Middle Last | 4. DATE OF DEATH<br><b>Nov. 7 1959</b> | Month Day Year |
|--|-------------------|--|----------------|

|                         |                                  |   |                                       |                                     |   |                |
|-------------------------|----------------------------------|---|---------------------------------------|-------------------------------------|---|----------------|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-23-1885</b> | 9. AGE (last birthday)<br><b>73</b> | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR |
|-------------------------|----------------------------------|---|---------------------------------------|-------------------------------------|---|----------------|

|   |  |   |                             |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine Operator-Liggett &amp; Myers Tob. Co.</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>St. Louis, Mo.</b> | 11. BIRTHPLACE (City and state or country)<br><b>U.S.A.</b> | 12. CITIZEN OF WHAT COUNTRY |
|---|--|---|-----------------------------|

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|--|---|---|
| 13a. FATHER'S NAME<br><b>John Reddington</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Hesson</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Late Robert Forrest</b> |
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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)<br><b>No None</b> | 16. SOCIAL SECURITY NO.<br><b>489-10-5287</b> | 17. INFORMANT Address<br><b>Marcella Boullier 4101a Bowen St.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>Coronary Sclerosis</b><br>DUE TO (b) <b>420.1</b><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)   |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                   |                                    |
|---|-----------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>Cabriel Taylor Carouas</b> | 22b. ADDRESS<br><b>1300 Clark</b> | 22c. DATE SIGNED<br><b>11.9.59</b> |
|---|-----------------------------------|------------------------------------|

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 23b. DATE<br><b>Nov. 10 1959</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co. Mo.</b> |
|---|----------------------------------|---|---|

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|---|---|--|
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Kriegshauser 4228 S.Kingshighway</b> | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 9 1959</b> | 26. REGISTRAR'S SIGNATURE<br><b>Earl Smith, M.D.</b> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*mjs*

**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 William B. White

Licensed Embalmer No. 4291

P. O. Address 4228 A St

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.