

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

**59-042955**

**FILED VS DEC 3 1959 17**

Registration District No. \_\_\_\_\_ Primary Registration District No. **500** Registrar's No. **3005**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b>		Length of stay in 1b <b>10 days</b>		c. CITY OR TOWN <b>Belleville</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy Osteopathic Hospital</b>				Inside Limits <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>123 So. Third St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle _____ Last <b>Watson</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1959</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>11/23/1888</b>			
				9. AGE (last birthday) <b>71</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>Henry Thompson</b>			13b. MOTHER'S MAIDEN NAME <b>Main Smith</b>			14. NAME OF HUSBAND OR WIFE <b>Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Blossom M. Pence, 1204 Kilgore Dr.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, diabetes</b> DUE TO (b) <b>coronary atherosclerosis</b> DUE TO (c) <b>arteriosclerosis heart disease</b> 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							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>		
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 _____ 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 <b>10/5/59</b> to <b>11/10/59</b> and last saw her/him alive on <b>11/10/59</b> . Death occurred at <b>10/14</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Albert H. Hoppe</b>				22b. ADDRESS <b>12011 Bellefontaine Rd (37)</b>			22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11-12-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>		23d. LOCATION (City, town, or county) <b>New Baden, Ill.</b>		(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>11-12-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>			

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 Harvey Kable  
Licensed Embalmer No. 4596  
P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.