

# FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

**FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE**

UNRECORDED

**FILED VS DEC 21 1959**

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 38459042204 STATE FILE NUMBER 4

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Adair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Length of stay in 1b <u>3 WKS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Nursing Home #1</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>KNOX</u> c. CITY OR TOWN <u>NOVELTY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Martha ELLEN Conder</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec. 14 1959</u>							
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>DEC 24, 1869</u>		<b>9. AGE</b> (last birthday) <u>89</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <u>NOVELTY, MO</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>			
<b>13a. FATHER'S NAME</b> <u>JAMES COCKRUM</u>				<b>13b. MOTHER'S MAIDEN NAME</b> <u>SUSAN POND BOGGS</u>				<b>14. NAME OF HUSBAND OR WIFE</b> <u>JOHN ELLIS CONDER</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>OLLIE SCEARCE</u>		Address <u>CALIF</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> DUE TO (b) <u>Coronary Thrombotic Occlusion</u> <u>Sudden</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> <u>unknown</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypoproteinemica nutritional in origin</u>								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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/>		<b>SUICIDE</b> <input type="checkbox"/>		<b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year											
<b>20d. INJURY OCCURRED WHILE AT WORK?</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)				<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>12-12-59</u> <b>to</b> <u>12-14-59</u> <b>and last saw her</b> <u>her</u> <b>alive on</b> <u>12-13-59</u> <b>Death occurred at</b> <u>3: 55</u> <b>P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
<b>22a. SIGNATURE</b> (Degree or title) <u>George A. Scheuren, D.O.</u>						<b>22b. ADDRESS</b> <u>Kirksville, Mo.</u>				<b>22c. DATE SIGNED</b> <u>12-14-59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE</b> <u>17 Dec 1959</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>COCKRUM CEMETERY</u>				<b>23d. LOCATION</b> (City, town, or county) (State) <u>NOVELTY, MO</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>HUDSON-RIMER FUNERAL HOME EDINIA, MO</u>						<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-18-1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Dorothy W. Patliff</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

GEORGE H. SCHEURER, D.O.

**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 George H. Scherer

Licensed Embalmer No. 504

P. O. Address Edina

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.