

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 8 3 7

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 277

RECEIVED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)	
a. COUNTY Franklin	a. STATE Missouri b. COUNTY Washington		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington	Length of stay in 1b 1 wk	c. CITY OR TOWN Richwoods	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Mark Middle Scalarando Last Scalarando	4. DATE OF DEATH	Month Dec. Day 20 Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-12-88	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) Richwoods, Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Saffra Scalarando	13b. MOTHER'S MAIDEN NAME Cecelia Emily	14. NAME OF HUSBAND OR WIFE Never Married
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT Sam Scalarando	Address Richwoods, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute cardiac decompensation	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Coronary myocardial infarction; Pulmonary edema.	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Superimposed respiratory infection.	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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	
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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 Richwoods, Mo	COUNTY	STATE
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21. I attended the deceased from **12/15/59** to **12/20/59** and last saw ^{her}him alive on **12/20/59**
Death occurred at **10:20 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>[Signature]</i>	22b. ADDRESS Washington, Mo.	22c. DATE SIGNED 12/23/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 24, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Stephens	23d. LOCATION (City, town, or county) Richwoods, Mo
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24. FUNERAL DIRECTOR Casey Lenox	ADDRESS St. Clair, Mo.	25. DATE RECD. BY LOCAL REG. 12/25/59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R. M. Lenoir*

Licensed Embalmer No. 3601

P. O. Address: St. Cloud, Fla.

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.