

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 6 8-3

FILED VS DEC 21 1959

211200

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution? Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2019 Lynch			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT DALE LONG				4. DATE OF DEATH Month Day Year Dec. 2- 1959			
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 Dec. 2-1959	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR 16hr
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Dale Long			13b. MOTHER'S MAIDEN NAME Mary Risk		14. NAME OF HUSBAND OR WIFE None		
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. None		17. INFORMANT Address Dale Long 2019 Lynch			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Empisematitis of Lung						INTERVAL BETWEEN ONSET AND DEATH Dec 2 1959	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Pre mature - 2 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7625					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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Dec 2 - 1959 to Dec 2 - 1959 and last saw her/him alive on Dec 2 - 1959 Death occurred at 10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE H.G. Moore M.D. (Degree or title)				22b. ADDRESS 917-5018		22c. DATE SIGNED 12-4-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 3-1959	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois				25. DATE RECD. BY LOCAL REG. DEC 3 1959		26. REGISTRAR'S SIGNATURE Neal Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m 813

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
Not Embalmed

Signed *P. P. Cline*
Licensed Embalmer No. _____
P. O. Address _____

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.