

FEDERAL BUREAU OF INVESTIGATION UNITED STATES DEPARTMENT OF JUSTICE

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UNDECEASED

FILED VS. JAN 15 1960 317

'59 0 4 6 3 6 1

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 3397

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Mo. b. COUNTY St. Louis (Submission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Koch		Length of stay in 1b 238 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5748 Lindenwood Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Ida Cullinane			4. DATE OF DEATH Month Day Year 12 18 59			
5. SEX Female	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-2-84	9. AGE (last birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and state or country) St. Louis		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME Jacobs Martini		13b. MOTHER'S MAIDEN NAME Elizabeth Himmihoffen		14. NAME OF HUSBAND OR WIFE William Cullinane		

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. 499-12-5621	17. INFORMANT Address Robt. Koch Hospital, Record Room Koch, 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 2 1/2 hrs
IMMEDIATE CAUSE (a) pulmonary thrombosis		
DUE TO (b) pulmonary tuberculosis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) 002+		

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	
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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 10-8-57 to 12-18-59 and last saw her/him alive on 12-17-59		Death occurred at 4:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Arcl R. Brown M.D.	22b. ADDRESS Robt. Koch Hosp., Koch, Mo.	22c. DATE SIGNED 12-18-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/21/59	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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24. FUNERAL DIRECTOR ADDRESS Collier Mortuary, St. Ann Mo.	25. DATE RECD. BY LOCAL REG. 12-19-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.
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(Licensed Embalmer's Statement on Reverse Side)

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 Sheldon Collier

Licensed Embalmer No. 338

P. O. Address St Ann

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.