

FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 7 1960

-59-047126

STATE FILE NUMBER

Registration District No. 20 Primary Registration District No. _____ Registrar's No. 40

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Clark DELAYED</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clay Township</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mississippi River</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Lee</u> c. CITY OR TOWN <u>Keokuk</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1517 Palau</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Michael Louis Schevers</u> 4. DATE OF DEATH Month Day Year <u>Dec. 8 1959</u> | | | | 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>1/2/1955</u> 9. AGE (last birthday) <u>4 yrs.</u> 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) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Keokuk Texas</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Vincent A. Schevers</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Jennie Land</u> | | 14. NAME OF HUSBAND OR WIFE _____ | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Vincent Schevers</u> Address <u>1517 Palau Keokuk Tx.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>(OVER)</u> DUE TO (c) _____ 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 type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>12-8-59</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>D. B. Chaunday, D.O. Coroner</u> | | | | 22b. ADDRESS <u>Kahoka mo</u> | | 22c. DATE SIGNED <u>6-16-60</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>June 15-1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial</u> | | 23d. LOCATION (City, town, or county) (State) <u>Lee Texas</u> | | |
| 24. FUNERAL DIRECTOR <u>Wes L. Tuttle - Tahoka Mo.</u> ADDRESS _____ | | | | 25. DATE RECD. BY LOCAL REG. <u>6/27-60</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Death occurred Dec 8th 1959

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 Arthur L. Sullivan

Licensed Embalmer No. 2965

P.O. Address Amesbury

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.