

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008636

FILED VS MAR 7 1960

2 1701

STATE FILE NUMBER

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

| | | | | | | | |
|---|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 44 yrs. | | 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 3948a Evans Ave. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3948a Evans Ave. | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First EUGENIA Middle D. Last MOORE | | | | 4. DATE OF DEATH Month Feb. Day 11 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE Col | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 5-8-1888 | 9. AGE (last birthday) 71 | IF UNDER 1 YEAR Months 9 Days 3 | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | | 10b. KIND OF BUSINESS OR INDUSTRY Columbus, Miss. | | 11. BIRTHPLACE (City and state or country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY |
| 13a. FATHER'S NAME William Witherspoon | | | 13b. MOTHER'S MAIDEN NAME Louellen Williams | | 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) No | | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT William F. Busch 5149a Lexington Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE (HEART) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | DUE TO (b) 434.1 | | 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 FEB 1, 1960 to FEB 11, 60 and last saw her/him alive on 2-11-60 Death occurred 11:30 on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) M. D. | | | | 22b. ADDRESS 822^a N. JEFFERSON | | 22c. DATE SIGNED 2-12-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 2-18-60 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park | | 23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. | | | |
| 24. FUNERAL DIRECTOR J. H. RANDLE & SON 3133 Bell Ave. | | | 25. DATE RECD. BY LOCAL REG. FEB 15 1960 | | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M. D. | | |

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 Esther N. Harr

Licensed Embalmer No. 445

P. O. Address 4181 W...

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.