

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

60-011961

MAR 16 1960

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 16

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Osage</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Crawford Township</u>		Length of stay in lb <u>life</u>		c. CITY OR TOWN <u>Crawford Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>On his Farm</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Hope, Mo., RFD</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>O.</u> Last <u>Fent</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7or 8</u> Year <u>1960</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>Sept 19 1890</u>		9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>selfemployed</u>			11. BIRTHPLACE (City and state or country) <u>Hope, Mo.</u>			12. CITIZEN OF WHAT COUNTRY <u>United States</u>				
13a. FATHER'S NAME <u>William Fent</u>			13b. MOTHER'S MAIDEN NAME <u>Hattie Schroeder</u>			14. NAME OF HUSBAND OR WIFE <u>Never Married</u>							
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>Mrs. August Ochesky, Linn, Mo.</u>			Address					
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>Complete Exhaustion due to Malnutrition</u> DUE TO (b) <u>Exposure to outside zero weather</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Body was completely covered with snow for several days</u>								INTERVAL BETWEEN ONSET AND DEATH					
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 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.) <u>He left the house to feed stock and apparently</u>									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>collapsed on the way in heavy snow storm.</u>													
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.) <u>On Farm</u>		20f. CITY, TOWN, OR LOCATION <u>Pershing, Mo. R.R. Osage</u>		COUNTY <u>Missouri</u>		STATE					
21. I attended the deceased from _____ to _____ and last saw him xxx on <u>March 13th, 1960</u> Death occurred at <u>After 3/7/1960</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Clyde Morton</u> (Degree or title) <u>Coroner</u>				22b. ADDRESS <u>Linn, Mo.</u>		22c. DATE SIGNED <u>3/14/1960</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shirley</u>		23d. LOCATION (City, town, or county) <u>Chambers R.D., Mo.</u>		(State)					
24. FUNERAL DIRECTOR <u>Clyde Morton</u> ADDRESS <u>Linn, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>3/14/1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clyde Morton</u>							

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 Wm. M. Norton

Licensed Embalmer No. 4125

P. O. Address Levin W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.