

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

-60-016564

FILED VS APR 22 1960

Registration District No. _____ Primary Registration District No. _____ Registrar No. **4114** STATE FILE NUMBER

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, MO		Length of stay in 1b	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 ST. LOUIS CITY HOSP. #1.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5896 Delmar Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle IRENE Last ALLEN			4. DATE OF DEATH APRIL 12, 1960 Month Day Year		
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5. SEX Female	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 7/20/1883	9. AGE (last birthday) 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Waitress	10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (City and state or country) Effingham, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.
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13a. FATHER'S NAME Samuel Allen	13b. MOTHER'S MAIDEN NAME Elizabeth Watts	14. NAME OF HUSBAND OR WIFE None
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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. 489-01-0400	17. INFORMANT Address Mary Jane Buell, 5896 Delmar
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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
IMMEDIATE CAUSE (a) Subarachnoid hemorrhage		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis	
	DUE TO (c) 330X	

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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **3/21/60** to **4/12/60** and last saw her/him alive on **4/12/60**
Death occurred at **9:50 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert K Lane M.D.	22b. ADDRESS 1515 LAFAYETTE AVE	22c. DATE SIGNED 4/12/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-15-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	23d. LOCATION (City, town, or county) (State) Belleville, Ill.
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24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. APR 14 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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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 Melvin R. Kempe

Licensed Embalmer No. 4055

P. O. Address St Louis

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