

FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

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FILED VS JUL 6 1960

-60-024250

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 263

ENDED

1. PLACE OF DEATH a. COUNTY St. Francois				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Farmington - rural		Length of stay in 1b _____		c. CITY OR TOWN Farmington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Thomas-Dell Nursing Home			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 721 Warren		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Edna Middle Florence Last Counts				4. DATE OF DEATH Month June Day 29 Year 1960									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/31/1882		9. AGE (last birthday) 78		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) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ste Genevieve Co., Mo.				11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Willis B. Johnson				13b. MOTHER'S MAIDEN NAME Martha Anderson				14. NAME OF HUSBAND OR WIFE Marion C. Counts					
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. Marion C. Counts				17. INFORMANT Address Farmington, Missouri					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis 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										INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 years			
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 <u>June 21, 1960</u> to <u>June 29, 1960</u> and last saw her <u>6/29/60</u> alive on Death occurred at <u>9:30</u> A <u>am</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>W. H. ...</i> (Degree or title)					22b. ADDRESS Farmington Mo					22c. DATE SIGNED 6/30/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/1/60		23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery			23d. LOCATION (City, town, or county) Farmington Missouri			(State) _____			
24. FUNERAL DIRECTOR Miller Funeral Home Farmington, Mo.				ADDRESS _____		25. DATE RECD. BY LOCAL REG. July 1, 1960		26. REGISTRAR'S SIGNATURE <i>Ether R. ...</i>					

(Licensed Embalmers Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 16 1961

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 Paul H. Dugal

Licensed Embalmer No. 4120

P. O. Address Farmingdale

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.