

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

-60-033792

FILED VS. SEP 19 1960

38

Primary Registration District No. 3006

Registrar's No. 512

STATE FILE NUMBER

INDEXED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Boone				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY CLARK			
b. CITY (If outside corporate limits, give TOWNSHIP only) Columbia		Length of stay in 1b 5 days		c. CITY OR TOWN KAHOKA		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION UNIVERSITY OF MO. Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rural			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle FRANKLIN Last Boone				4. DATE OF DEATH Month 9 Day 10 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-1-66	9. AGE (last birthday) 94	IF UNDER 1 YEAR Months 9 Days 10	IF UNDER 24 HR Hours 60 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) CLARK CO. MO.	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME William Boone			13b. MOTHER'S MAIDEN NAME Sarah Jane Busby		14. NAME OF HUSBAND OR WIFE LINNE BOONE		
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.		17. INFORMANT UNIVERSITY OF MO. MEDICAL RECORDS 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) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH Months YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture of Rt Hip					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.) FALL					
20c. TIME OF INJURY Hour 9 Month, Day, Year 3 60 P.M.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 9-5-60 to 9-10-60 and last saw her him alive on 9-9-60 Death occurred at 1:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Ralph H Bender M.D.				22b. ADDRESS University Hospital Columbia Mo.		22c. DATE SIGNED 10/6/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-10-1960	23c. NAME OF CEMETERY OR CREMATORY Chambersburg Cem.		23d. LOCATION (City, town, or county) (State) CHAMBERSBURG, Mo			
24. FUNERAL DIRECTOR Parsons Funeral Service, Columbia Mo			25. DATE RECD. BY LOCAL REG. Sept 10 1960		26. REGISTRAR'S SIGNATURE Mr R E Palmer		

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

J. W. Phillips

Licensed Embalmer No. 4897

P. O. Address Columbus

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