

FEDERAL BUREAU OF INVESTIGATION
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS JAN 13 1967

-60-047470

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12666**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI			a. STATE MISSOURI		b. COUNTY <i>St. Louis</i>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			c. CITY OR TOWN MARLBOROUGH		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. STREET ADDRESS 8013 PILGRIM DRIVE			d. STREET ADDRESS (if outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First JOHN Middle PAUL Last FARRELL, JR.			Month DECEMBER Day 31 Year 1960		
5. SEX MALE	6. COLOR OR RACE MCAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1927	9. AGE (last birthday) 33	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKMASON		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and state or country) MEMPHIS, TENNESSEE		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME JOHN P. FARRELL, Sr.		13b. MOTHER'S MAIDEN NAME MAYME HOPPER		14. NAME OF HUSBAND OR WIFE ROSEMARY FARRELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WORLD WAR II		16. SOCIAL SECURITY NO. 451-32-1479		17. INFORMANT ROSEMARY FARRELL Address SEE #2	
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) METASTATIC ADENOCARCINOMA OF BRAIN, PRIMARY SITE UNKNOWN					1 YEAR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____					
DUE TO (c) _____ 1930					
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 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. 7, 1960 to DEC. 31, 1960 and last saw her DEC. 31, 1960 Death occurred at 1:20 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. E. Vermillion, M.D.</i> (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 12/31/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1/3/1961	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI		
24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET ST. LOUIS, MISSOURI		25. DATE RECD. BY LOCAL REG. JAN 3 1961	26. REGISTRAR'S SIGNATURE <i>Loed Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MISSOURI BOARD OF HEALTH
DIVISION OF PUBLIC HEALTH

STATE OF MISSOURI, COUNTY OF _____, CITY OF _____

STATE OF MISSOURI, COUNTY OF _____, CITY 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. _____

X

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Bill C. Hanson

Licensed Embalmer No. 1269

P. O. Address St Louis, Mo

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.