

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 27 1960

-60-048489

STATE FILE NUMBER

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 109

1. PLACE OF DEATH a. COUNTY <u>SULLIVAN</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MILAN</u> Length of stay in 1b <u>8 DAYS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>SULLIVAN COMMUNITY HOSPITAL</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SULLIVAN</u> c. CITY OR TOWN <u>POLOCK</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>SAMUEL</u> Last <u>SCOBEE</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>18</u> Year <u>1960</u>															
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-88</u>		9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GEN FARMING</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <u>MARTINSTOWN MO</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13a. FATHER'S NAME <u>Geo W SCOBEE</u>						13b. MOTHER'S MAIDEN NAME <u>MARTHA A MONTGOMERY</u>						14. NAME OF HUSBAND OR WIFE <u>MARY B SCOBEE</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>Louise Scobee</u> Address <u>Milan, Mo</u>							
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>Cerebral hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>12-10-60</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Paraplegia of neck</u> <u>12-10-60</u> DUE TO (c) <u>Hypertension</u> <u>yes?</u>																			
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 <u> </u> a.m. <u> </u> p.m. <u> </u>				Month, Day, Year <u> </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.)				20f. CITY, TOWN, OR LOCATION				COUNTY				STATE			
21. I attended the deceased from <u>12-10-60</u> to <u>12-18-60</u> and last saw <u>her</u> alive on <u>12-18-60</u> Death occurred at <u>4:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>E. W. Simpson D.O.</u> (Degree or title)						22b. ADDRESS <u>Milan.</u>						22c. DATE SIGNED <u>12-20-60</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				23b. DATE <u>Dec 20 1960</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Seabee</u>				23d. LOCATION (City, town, or county) (State) <u>Pollock, Mo</u>							
24. FUNERAL DIRECTOR <u>Leggins Funeral Home - Milan</u> ADDRESS <u> </u>						25. DATE RECD. BY LOCAL REG. <u>12-21-60</u>						26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</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 Lawrence Duggan

Licensed Embalmer No. 3793

P. O. Address Melrose

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.