

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36097

109 10

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 362 PRIMARY REG. DIST. NO. 4531 Registrar's No. 511

1. PLACE OF DEATH a. COUNTY <b>Warren</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Warrenton</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Farmington Mo.</b>	
c. LENGTH OF STAY (in this place) <b>8 weeks</b>		94 4	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Katie Jane Home</b>		d. STREET ADDRESS (If rural, give location) <b>none</b>	
3. NAME OF DECEASED a. (First) <b>Malinda</b>		b. (Middle) <b>Hope</b>	
c. (Last) <b>Adams</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 5 49</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 5 70</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>St. Francis County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>John Hunt</b>		13b. MOTHER'S MAIDEN NAME <b>America <del>Hunt</del> UNKNOWN</b>	
14. NAME OF HUSBAND OR WIFE <b>James Adams</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Otis Hagood</b> ADDRESS <b>St. Peters Mo</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Congestive Heart Failure</b> DUE TO (c) <b>Failure</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pulmonary Hypertension with 4227</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>Aug. 7, 1949</b> , to <b>Oct 3, 1949</b> , that I last saw the deceased alive on <b>Oct 3, 1949</b> , and that death occurred at <b>10:20pm.</b> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <b>H. H. Schelske M.D.</b>		23b. ADDRESS <b>Warrenton, Missouri</b>	
23c. DATE SIGNED <b>Oct. 5</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	
24b. DATE <b>Oct. 6</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Parkview Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Francis Co. Mo.</b>		DATE REC'D BY LOCAL REG. <b>Oct 5 49</b>	
REGISTRAR'S SIGNATURE <b>Hayd Hagood</b>		5. FUNERAL DIRECTOR'S SIGNATURE <b>Beal L. Boyer Leadwood Mo</b>	
ADDRESS		ADDRESS	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

District File Number \_\_\_\_\_  
District Health Officer No. 9,  
RECEIVED OCT 17 1949

OCT 22 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Bert L. Boyer*

Licensed Embalmer No. *3445*

P. O. Address

*Leadwood 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 this body is not embalmed, fact should be so stated above.