

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **2819**
Registrar's No. **0892**

FILED FEB 3 1953

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY Missouri			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis		c. LENGTH OF STAY (In this place) 7 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR St. Louis 2121	
d. FULL NAME OF HOSPITAL OR INSTITUTION Masonic Hospital			d. STREET ADDRESS (If rural, give location) 12 5351 Delmar		
3. NAME OF DECEASED (Type or Print) a. (First) Ella		b. (Middle) _____		c. (Last) Adams	
4. DATE OF DEATH (Month) (Day) (Year) 1-25-53		5. SEX F			
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W		8. DATE OF BIRTH 9-29-1864	
9. AGE (In years last birthday) 88		10. MONTHS 4		11. DAYS 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse			10b. KIND OF BUSINESS OR INDUSTRY _____		
11. BIRTHPLACE (City and State or Foreign Country) Westville, Ohio			12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME Jasper W. Grant		13b. MOTHER'S MAIDEN NAME Mary Catheran Chance		14. NAME OF HUSBAND OR WIFE Mathias M. Adams, deceased	
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. None		17. INFORMANT'S SIGNATURE OR NAME Supt. Masonic Home of Missouri, 5351 Delmar	
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. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Rectum DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 154X	
22. I hereby certify that I attended the deceased from 11-16- , 19 46 to 1-25- , 19 53 that I last saw the deceased alive on 1-25- , 19 53 , and that death occurred at 9-45 Pm. , from the causes and on the date stated above.					
23a. SIGNATURE Edgar A. Davis		23b. ADDRESS 508 N. Grand		23c. DATE SIGNED 1-26-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE Jan. 26, 1953		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE W. Alexander & Sons			
DATE REC'D BY LOCAL REG. JAN 26 1953		REGISTRAR'S SIGNATURE Carl Smith			

(Licensed Embalmer's Statement on Reverse Side)

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

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

Jos. E. McCallister

Licensed Embalmer No. *2460*

P. O. Address *6130 Delmar*

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.