

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8799

State File No.

332

BIRTH NO.		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>Buchanan.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Caldwell.</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 yrs 7 M. 25 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Beckauridge.</u>		<u>0130</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No. 2.</u>				d. STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>HATTIE</u>		a. (First)		b. (Middle) <u>—</u>		c. (Last) <u>ADAMS.</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>3-11-1953.</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	
8. DATE OF BIRTH <u>12-26-1908.</u>		9. AGE (In years last birthday) <u>44</u>		10. UNDER 1 YEAR Months <u>2</u> Days <u>15</u>		11. UNDER 1 MRS. Hours <u>/</u> Min. <u>/</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None.</u>		11. BIRTHPLACE (State or foreign country) <u>Beckauridge, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Cash Adams.</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Lois Caskatt</u>		14. NAME OF HUSBAND OR WIFE <u>/</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'S SIGNATURE OR NAME ADDRESS <u>Cash Adams - Beckauridge, Missouri</u>			
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) <u>Pulmonary tuberculosis.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>recanal defective.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>Since 9 years ago</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		002 X		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		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 <u>11-21-</u> , 1950, to <u>3-11-</u> , 1953, that I last saw the deceased alive on <u>3-10-</u> , 1953, and that death occurred at <u>3 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Forrest Thomas.</u>		(Degree or title) <u>M.D.</u>		23b. ADDRESS <u>State Hospital No. 2, St. Joseph, Missouri</u>		23c. DATE SIGNED <u>3-11-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3/11/1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Beckauridge, Missouri</u>		24d. LOCATION (City, town, or county) (State) <u>Beckauridge, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Mar 19, 1953</u>		REGISTRAR'S SIGNATURE <u>Dr. P. Balmain</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton-Sawyer Funeral Home - St. Joseph, Mo.</u>		ADDRESS	

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

James P. Hawkins

Signed
Student Embalmer

Licensed Embalmer No. 4531

P. O. Address 319 E. 10th St. Joseph

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.