

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26075

FILED JUL 31 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6063**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
e. STREET ADDRESS 11 1309 A Prairie		2119 2119			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Lewis			b. (Middle)		
c. (Last) Adams			June 14 1953		

5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 14, 1891	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 10	IF UNDER 1 HRS. Hours 1	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY Industry	11. BIRTHPLACE (City and State or Foreign Country) OKolona Miss	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Lewis Adams	13b. MOTHER'S MAIDEN NAME Amanda Acox	14. NAME OF HUSBAND OR WIFE Geneva Adams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 497-186072	17. INFORMANT'S SIGNATURE OR NAME	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Failure		
	ANTECEDENT CAUSES DUE TO (b) Hypertensive Cardiovascular Disease Undet. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 443X
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22. I hereby certify that I attended the deceased from **6-6**, 19**53**, to **6-14**, 19**53**, that I last saw the deceased alive on **6-14**, 19**53**, and that death occurred at **9:12 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Edw B Williams M.D. (Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 6-15-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 6-22-53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St Louis Count
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DATE REC'D BY LOCAL REG. JUN 17 1953	REGISTRAR'S SIGNATURE J Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W B France	ADDRESS 1221 Nevada
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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.....
Signature of Student Embalmer

Signed Lawrence Adams.....

Licensed Embalmer No. 4758

P. O. Address 1221 ne

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.