

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45020

FILED JAN 18 1954

State File No. _____

Registrar's No. _____

BIRTH NO. _____		REG. DIST. NO. <u>100</u>		PRIMARY REG. DIST. NO. <u>3018</u>		State File No. _____		Registrar's No. <u>101</u>	
1. PLACE OF DEATH a. COUNTY <u>Dent</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mis sour-i</u> b. COUNTY <u>Dent</u> <u>2350</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Salem</u>				c. LENGTH OF STAY (in this place) <u>22 hrs</u>		c. CITY OR TOWN _____		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hart Clinic</u>				e. STREET ADDRESS (If rural, give location) <u>Watkins Township</u>					
3. NAME OF DECEASED (Type or Print) <u>VINCENT</u>				a. (First) _____ b. (Middle) _____ c. (Last) <u>ADAMICK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 29 1953</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan 22, 1901</u>		9. AGE (In years last birthday) <u>52</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Adamick</u>				13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ratha</u>		14. NAME OF HUSBAND OR WIFE <u>Sophie Adamick</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>343-05-3822</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sophie Adamick Anutt, Mo.</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>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Atherosclerosis ?</u> DUE TO (c) <u>Diabetes Mellitus</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>Imm.</u> <u>4 yrs</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						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) <u>260 X</u>					
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 <u>12-28</u> , 19 <u>53</u> , to <u>12-29</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>12-29</u> , 19 <u>53</u> , and that death occurred at <u>9:20 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Joy E. Mitchell M.D.</u>				23b. ADDRESS <u>Salem, Mo.</u>		23c. DATE SIGNED <u>12/30/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Dec 31 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Collinsville Illinois</u>			
DATE REC'D BY LOCAL REG. <u>12-30-53</u>		REGISTRAR'S SIGNATURE <u>M. M. Hart, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Blackwell-Warpe Funeral Home Salem, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 1 1954

FEB 25 1954

FEB 26 1954

FEB 26 1954

JAN -

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 Max L. Warfel

Licensed Embalmer No. 4170

P. O. Address Salem, Ind.

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.