

FILED AUG 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26734

State File No. _____
Registrar's No. 45

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 486

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sullivan</u>		c. CITY OR TOWN <u>Sullivan</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>7 mo.</u>		e. STREET ADDRESS (If rural, give location) <u>Elmont Rd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Elmont Rd.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>NORMAN</u> b. (Middle) <u>W</u> c. (Last) <u>ADAMS</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8 19 1954</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>11-2-1915</u>		9. AGE (In years last birthday) <u>38</u>		10. IF UNDER 1 YEAR Days <u>2</u> IF UNDER 24 HRS. Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Salem Mo.</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>Salem Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			

13a. FATHER'S NAME <u>George M Adams</u>		13b. MOTHER'S MAIDEN NAME <u>Bertie Eastman</u>		14. NAME OF HUSBAND OR WIFE <u>Bernice Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World # 2</u>		16. SOCIAL SECURITY NO. <u>492-07-4178</u>		17. INFORMANT'S SIGNATURE OR NAME <u>George Adams</u> ADDRESS <u>Sullivan 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, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year.</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intermediate glioma of Spinal Cord</u>		
		DUE TO (c) <u>Kidney Calculus Right + Right Nephrectomy Feb 1954</u>		
19a. DATE OF OPERATION <u>Feb 1-1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Intermediate Glioma of Spinal Cord,</u>		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) _____		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 Jan 22, 1954, to Aug 19, 1954, that I last saw the deceased alive on Aug 19, 1954, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Robert C. Crawford M.D.</u> (Degree or title)		23b. ADDRESS <u>Sullivan Mo.</u>		23c. DATE SIGNED <u>Aug 20, 54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-22-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Sullivan Mo.</u>	

DATE REC'D BY LOCAL REG. <u>8-21-54</u>		REGISTRAR'S SIGNATURE <u>Thomas A. Humphrey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thos R. Shaffer</u> ADDRESS <u>Sullivan Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

VS JUL 7 1959

SEP 27 1959

SEP 7 1959

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 me Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed Paul F. Krollenb.

Licensed Embalmer No. 263

P. O. Address Sullivan 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.