S. No. 300
v. 10-48

FILED FEB 17 1956

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 6059

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 764

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

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BARNES HOSPITAL

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: Lawrence
c. CITY OR TOWN: Lawrenceville
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): R. R. # 2

812 8

**3. NAME OF DECEASED** (Type or Print): a. (First) Helen b. (Middle) NMN c. (Last) Adams

**4. DATE OF DEATH** (Month) (Day) (Year): January 22, 1956

**5. SEX**: Female
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married
**8. DATE OF BIRTH**: Sept. 5, 1909
**9. AGE** (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: At Home
**11. BIRTHPLACE** (City and State or Foreign Country): Sullivan, Indiana
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Charles Carlin
**13b. MOTHER'S MAIDEN NAME**: Unknown
**14. NAME OF HUSBAND OR WIFE**: Alex Adams

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No. (If yes, give war or dates of service): Nil.
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME** / ADDRESS: Alex Adams, Lawrenceville, Ill.

**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.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Tumor - left temporal parietal Malignant — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
*Morbid 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.*

**19a. DATE OF OPERATION**: 1/21/56
**19b. MAJOR FINDINGS OF OPERATION**: As Above 193x
**20. AUTOPSY?** YES ☐ NO ☒

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Jan 19, 1956, *to* Jan. 22, 1956, *that I last saw the deceased alive on* Jan. 22, 1956, *and that death occurred at* 2:45 P m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): C. P. Vermillion, M.D. M. D.
**23b. ADDRESS**: BARNES HOSPITAL
**23c. DATE SIGNED**: 1/22/56

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 1-23-56
**24c. NAME OF CEMETERY OR CREMATORY**: Local
**24d. LOCATION** (City, town, or county) (State): Vincennes, Ind.

**DATE REC'D BY LOCAL REG.**: JAN 23 1956
**REGISTRAR'S SIGNATURE**: J. Earl Smith M.D. MJB
**25. FUNERAL DIRECTOR'S SIGNATURE** / ADDRESS: Albert H. Hoppe 4700 Washington,

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. G. W. Wilkinson

Licensed Embalmer No. 35-

P. O. Address. St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai 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.