

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **9919**

FILED APR 2 - 1956

BIRTH NO. _____		REG. DIST. NO. <u>239</u>		PRIMARY REG. DIST. NO. <u>4356</u>		Registrar's No. <u>9</u>	
1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Parma</u>		c. LENGTH OF STAY (in this place) <u>44 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Parma</u>		d. STREET ADDRESS (If rural, give location) <u>0720</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Charley</u>		b. (Middle) <u>Arthur</u>		c. (Last) <u>Adkins</u>	
4. DATE OF DEATH		Mar.		9		1956	
5. SEX <u>M</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>March, 3 1974</u>	
9. AGE (in years last birthday) <u>82</u>		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) <u>retired railroad worker</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Morganfield Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Tom Adkins</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Sissel</u>		14. NAME OF HUSBAND OR WIFE <u>Annie Lee Adkins</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 <u>Annie Lee Adkins</u> ADDRESS <u>Parma 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.		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>hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331x</u>				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) (Min.)		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 <u>3/7</u> , 19 <u>56</u> , to <u>3/9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>3/7</u> , 19 <u>56</u> , and that death occurred at <u>9:40P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. Gresh W. Husted, MD</u>				23b. ADDRESS <u>Parma Mo.</u>		23c. DATE SIGNED <u>3/13/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Mar. 13, 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Garden Of Memories</u>		24d. LOCATION (City, town, or county) (State) <u>Stanton Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3/13/56</u>		REGISTRAR'S SIGNATURE <u>Dr. Gresh W. Husted, MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Watkins Funeral Service</u>		ADDRESS <u>Parma Mo;</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

DATE RECEIVED MAR 26 1956
NEW MADRID CO. HEALTH CENTER
P. J. L.

APR 3 1956

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
Student Embalmer

Signed Marsh Watkins

Licensed Embalmer No. 4717

P. O. Address Decker 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 this body is not embalmed, fact should be so stated above.