

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22700

FILED AUG 15 1956

State File No. 157

BIRTH NO. _____		REG. DIST. NO. 10		PRIMARY REG. DIST. NO. 3002		Registrar's No. 157	
1. PLACE OF DEATH a. COUNTY Audrain				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Audrain			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mexico		c. LENGTH OF STAY (In this place) 10 days		c. CITY OR TOWN Mexico		d. Is residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF HOSPITAL OR INSTITUTION Audrain Hospital				e. STREET ADDRESS (If rural, give location) 711 W. Breckenridge 0042			
3. NAME OF DECEASED (Type or Print) a. (First) Ollie		b. (Middle) Mae		c. (Last) Adams		4. DATE OF DEATH (Month) (Day) (Year) Aug. 7, 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, OR FORCED (Specify) Married		8. DATE OF BIRTH June 15, 1885	
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) Boone Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during usual working hours, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home					
13a. FATHER'S NAME John Ewens		13b. MOTHER'S MAIDEN NAME Mary Ann Roberts		14. NAME OF HUSBAND OR WIFE Joe C. Adams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joe C. Adams, Mexico, Mo.			
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, aneurysm, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Sarcinoma</u> ANTECEDENT CAUSES Morbidity 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. INTERVAL BETWEEN ONSET AND DEATH 2 yrs.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 March 3, 1956, to Aug 7, 1956, that I last saw the deceased alive on Aug 7, 1956, and that death occurred at 2:15 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) William J. Adams		23b. ADDRESS 112 N. Clark		23c. DATE SIGNED 8/9/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 9, 1956		24c. NAME OF CEMETERY OR CREMATORY Eastlawn		24d. LOCATION (City, town, or county) (State) Audrain Co., Mo.	
DATE REC'D BY LOCAL REG. Aug. 9-1956		REGISTRAR'S SIGNATURE Blanche Neely		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mexico, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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.....

Eal E. Puck

Licensed Embalmer No. 3189

P. O. Address Mexico, 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.