

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 28 1956

STATE FILE NUMBER 37849

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1764

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Jackson</i>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <i>Kansas City</i>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <i>Kansas City</i>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>     |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph Hospital</i>  |                                  |   | Length of stay in bed <i>70 yrs.</i>   | d. STREET ADDRESS (If outside, give location) <i>5539 Brooklyn</i>       |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Maggie</i> Middle <i>D.</i> Last <i>Adamson</i>   |                                  |   | 4. DATE OF DEATH<br>Month <i>Nov</i> Day <i>2</i> Year <i>1956</i>   |  |   |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Sept. 4-1870</i>  | 9. AGE (In years last birthday)<br><i>86</i>                             | IF UNDER 1 YEAR<br>Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>at Home</i>   | 11. BIRTHPLACE (City and state or country)<br><i>Indiana</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S. A.</i>                                |
| 13. FATHER'S NAME<br><i>Samuel Decker</i>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><i>Unknown</i>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>—</i>   | 17. INFORMANT Address<br><i>Floyd Adamson, 5539 Brooklyn</i>   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>DUE TO (b) <i>senile arterial changes</i><br>DUE TO (c) <i>3 days</i><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <i>331X</i><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>—</i> |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i><br><i>331X</i>              |
| 20a. ACCIDENT <input type="checkbox"/>  | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><i>—</i>                                   |  |   |
| 20c. TIME OF INJURY<br>Hour <i>—</i> Month <i>—</i> Day <i>—</i> Year <i>—</i><br>a. m. <i>—</i> p. m. <i>—</i>   |                                  |   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                          |  |   |
| 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><i>—</i>   |                                  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY   | STATE   |
| 21. I attended the deceased from <i>1955</i> to <i>Nov 2, 1956</i> and last saw her/him alive on <i>Nov 2, 1956</i> .<br>Death occurred at <i>7:30 A.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |   |  |  |   |
| 22a. SIGNATURE (Degree or title)<br><i>James I. Ferguson</i>  |                                  |   | 22b. ADDRESS<br><i>410 Bryant Blvd</i>   |  | 22c. DATE SIGNED<br><i>Nov 5/56</i>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 23b. DATE<br><i>Nov. 5-1956</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Washington Cem.</i>  |  | 23d. LOCATION (City, town, or county) (State)<br><i>Kansas City, Mo.</i> |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><i>C. H. Blackman + Son - K. C. - Mo.</i>   |                                  | 25. DATE REC'D. BY LOCAL REG.<br><i>11-5-56</i>   | 26. REGISTRAR'S SIGNATURE<br><i>Reva Minshall</i>  |  |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE, IF POSSIBLE  
James I. Ferguson M. D.

MEDICAL CERTIFICATION

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 *W.C. Reine*

Licensed Embalmer No. *48*

P. O. Address *K.C., Mo.*

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