

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2220**

FILED JAN 14 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **274** PRIMARY REG. DIST. NO. **3052** Registrar's No. **79**

1. PLACE OF DEATH a. COUNTY <b>PETTIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>PETTIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SEDALIA</b>	c. LENGTH OF STAY (In this place) <b>10 months</b>	c. CITY OR TOWN <b>SEDALIA</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1001 WEST 10TH</b>		e. STREET ADDRESS (If rural, give location) <b>1001 WEST 10TH</b>	

3. NAME OF DECEASED (Type or Print) <b>ELIZABETH</b>	a. (First)	b. (Middle)	c. (Last) <b>ADAMS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JAN 9 1957</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 23, 1881</b>	9. AGE (In years less birthday) <b>75</b>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MINS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Otterville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Steven Zumsteg</b>	13b. MOTHER'S MAIDEN NAME <b>Dora Kaiser</b>	14. NAME OF HUSBAND OR WIFE <b>Name could not be learned</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>J.E. Lowery, Syracuse, Mo.</b>	ADDRESS
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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.	MEDICAL CERTIFICATION <b>Cerebral Hemorrhage. Only a few minutes.</b>		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)  ANTECEDENT CAUSES <b>Cardio-Vascular Disease with Hypertension. I dont know.</b>		
	DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <b>Arterio- Sclerosis. Advanced.</b>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Medical care only. See other side.</b>	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None.</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <b>None.</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **12-5-56**, 19\_\_\_, to **1-9-57**, 19\_\_\_, that I last saw the deceased alive on **12-5-56**, 19\_\_\_, and that death occurred at **5:50 P.M.** from the causes and on the date stated above.

23a. SIGNATURE <b>Jno. B. Carlisle, M.D.</b>	(Degree or title)	23b. ADDRESS <b>Sedalia, Missouri.</b>	23c. DATE SIGNED <b>1-11-57</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1/11/1957</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>1-11-57</b>	REGISTRAR'S SIGNATURE <b>Lavinia Cooney, Deputy</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>D.W. Heckart</b>	ADDRESS <b>Sedalia, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

GILLESPIE FUNERAL HOME

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I saw this lady on December 5th, 1956 and did not see her again. When I arrived at her home she was dead. I believe that she suffered a Cerebral Hemorrhage.

*J. B. Carlisle M.D.*  
Jno. B. Carlisle, M.D.

Sedalia, Missouri,

January 11th, 1957.

JAN 22 1957

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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 *Roger T. Fuller* .....

Licensed Embalmer No. 4818

P. O. Address Sedalia, 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.