

Health,  
Welfare  
Public  
Service

300  
1-56

All  
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 3 1957

318

1003

18386  
STATE FILE NUMBER

4719  
Registrar's No.

Registration District No. Primary Registration District No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute to City Hospital			Length of stay in lb 23 1/2		d. STREET ADDRESS 1614a S. 18th (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last MERLE LEON ADAMS			4. DATE OF DEATH Month Day Year 5 18 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-1925		9. AGE (In years last birthday) 32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooler Man		10b. KIND OF BUSINESS OR INDUSTRY Esquire Ice Cream		11. BIRTHPLACE (City and state or country) Sumner, Illinois	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Adams		
14. MOTHER'S MAIDEN NAME Eva Greemore			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Barbara Adams, 1614a S. 18th		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of Skull and Brain; Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (1)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of form) Self inflicted in his home around 3:30 p.m. May 18th 1957 while suffering from mental aberration. E9.76x			
20c. TIME OF INJURY Hour Month, Day, Year 3:30 p.m. 5 18 57		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, school, office bldg., etc.) Home		20e. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Mo	
20f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ 3:34 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James M. Kelly, County Coroner			22b. ADDRESS 1300 Clark		22c. DATE SIGNED 5-20-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-22-57	23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette		ADDRESS		25. DATE RECD. BY LOCAL REG. MAY 20 '57	26. REGISTRAR'S SIGNATURE Carl Smith, MO

(Licensed Embalmer's Statement on Reverse Side)

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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 *L. R. Coap*.....

Licensed Embalmer No. *36*.....

P. O. Address *2317 Ka*.....

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.