

Health,
We Care
Public
Service

FILED NOV 14 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

356331
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5042

9. 300
y. 1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Norborne</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hosp</u>		Length of stay in 1b <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>100 E 3rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>William Levi</u> Middle <u>Adams</u> Last <u>Adams</u>			4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>57</u>		
--	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24 1878</u>	9. AGE (In years last birthday) <u>78</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>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>Carroll Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	---	---

13a. FATHER'S NAME <u>William Horace Adams</u>	13b. MOTHER'S MAIDEN NAME <u>Irene White</u>	14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</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>UNKNOWN</u>	17. INFORMANT <u>Nelen McClean</u> Address <u>Norborne Mo</u>
--	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombocytopenic purpura</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	2967
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

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.)
---	--

20c. TIME OF INJURY a.m. _____ p.m. _____	Month, Day, Year _____
--	------------------------

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	--	--

21. I attended the deceased from <u>Apr 17 1951</u> to <u>Oct 30-57</u> and last saw her alive on <u>Oct 29-1957</u> Death occurred at <u>4:12 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert Davis M.D.</u> (Degree or title) <u>0</u>	22b. ADDRESS <u>870 prof Bldg KCMo</u>	22c. DATE SIGNED <u>10/30/57</u>
--	---	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-30-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	23d. LOCATION (City, town, or county) (State) <u>Norborne Mo</u>
---	------------------------------	--	---

25. DATE RECD. BY LOCAL REG. <u>10-30-57</u>	26. REGISTRAR'S SIGNATURE <u>neva minishall</u>
---	--

FUNERAL DIRECTOR <u>Deitch Mortuary, Norborne Mo</u>		ADDRESS <u>Norborne Mo</u>	
---	--	-------------------------------	--

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Robert C. Davis.

MEDICAL CERTIFICATION



VS DEC 15 1959

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 *John R. Jordan*

Licensed Embalmer No. *4531*
P. O. Address *Kansas City*

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.