

FILED JAN 30 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH1856
STATE FILE NUMBERRegistration District No. 383 Primary Registration District No. 5647 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Friestatt</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hoberg</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>Crest View Rest Home</u> Length of stay in 1b <u>1 year</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Allie</u> Middle <u>Murtle</u> Last <u>Adams</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>18</u> Year <u>1958</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-5-1880</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Lawrence Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah S. Allen</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Shook</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>491-42-5400</u>	17. INFIRMANT <u>Clint Adams</u> Address <u>Hoberg, Mo.</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
DUE TO (b) <u>generalized arteriosclerosis</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

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.) <u>334X</u>	
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>		
20d. INJURY OCCURRED WHILE AT WORK <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>1947</u> to <u>1/18/58</u> and last saw her alive on <u>1/17/58</u> Death occurred at <u>6:55 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>R. J. [Signature]</u> (Degree or title)	22b. ADDRESS <u>12 Vernon</u>
22c. DATE SIGNED <u>1/20/58</u>	

23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE <u>Jan-20-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>McKean, Mo.</u>
24. FUNERAL DIRECTOR <u>Max L. Foust</u>	ADDRESS <u>McKean, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-24-58</u>	26. REGISTRAR'S SIGNATURE <u>Cecil Hendricks</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

General Cemetery to be used for natural causes.

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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 e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Max L. Fossett*.....

Licensed Embalmer No. *4*.....

P. O. Address *Md. Va.*.....

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.