

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043921

STATE FILE NUMBER

FILED JAN 6 1959

Registration District No. 143

Primary Registration District No. 4557

Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE: (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Tomona</u>		c. CITY OR TOWN <u>Tomona</u> 0460	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>✓</u>		d. STREET ADDRESS (If outside, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Adams</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH <u>10-19-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		11. BIRTHPLACE (City and state or country) <u>Asper, Ala.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Alon Turner</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Eagle</u>	
14. NAME OF HUSBAND OR WIFE <u>✓</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u>	
16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Esther Adams, St Louis, 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>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u>4201</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>① DIABETES MELLITUS ② ARTERIOSCLEROSIS ③ SEVERITY</u>		19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>✓</u>	
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>MAY 24-58</u> to <u>DEC 19-58</u> . I last saw her alive on <u>DEC 16-58</u> . Death occurred at <u>8:00 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Jack N. Wiles, M.D.</u> (Doctor's title) <u>West Plains, Mo.</u>	
23a. BURNED, CREMATION, REMOVAL (Specify) <u>12-22-58</u>		23b. DATE <u>12-22-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Plains, Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>	
24. FUNERAL DIRECTOR <u>Tabernon, West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11/31/59</u>	
26. REGISTRAR'S SIGNATURE <u>Marshall Beeland</u>		27. DATE SIGNED <u>12-29-58</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 7 1953

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 *H. Robert*

Licensed Embalmer No. *3437*

P. O. Address *Elizabethton*

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.