

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006841
STATE FILE NUMBER
Registrar's 1813

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis,	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5206 S. 37th		d. STREET ADDRESS (If outside, give location) 5206 S. 37th	
3. NAME OF DECEASED (Type or print) First Middle Last James O. Adams			4. DATE OF DEATH Month Day Year Feb. 19, 1959
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 Oct. 12, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. 1st Public Serv. Bus Operator		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME Moses Adams		13b. MOTHER'S MAIDEN NAME Malissa Campbell	14. NAME OF HUSBAND OR WIFE Minnie Adams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO. 494-01-0328	17. INFORMANT Address Minnie Adams 5206 S. 37th St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) of arteriosclerosis & Cholesterol			
DUE TO (c) 331 X			
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? 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 Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Dec 1 - 68 to Feb 19 - 59 and last saw her alive on Feb 19 - 59 Death occurred at 8:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE W N Walters M.D. (Degree or title)		22b. ADDRESS 3608 S Grand	22c. DATE SIGNED 2/19/59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 2-23-59	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR'S ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. FEB 20 '59	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *David Lee Fosson*

Licensed Embalmer No. *4242*
P. O. Address: *514 Union St*

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.