

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021123

STATE FILE NUMBER

FILED JUN 16 1959

Registration District No.

140

Primary Registration District No.

3024

Registrar's No. 52

S. 300
1-57

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

1. PLACE OF DEATH a. COUNTY Howard		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Howard	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette, Mo.		c. CITY OR TOWN Fayette	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lee Hospital		d. STREET ADDRESS 111 E. Reynolds	
Length of stay in lb 1 hr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANNY Middle LEE Last ADAMS		4. DATE OF DEATH Month JUNE Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (In years last birthday) F UNDER 1 YEAR Months Days Hours Min. 1
11a. FATHER'S NAME Jerry Wayne Adams		11b. MOTHER'S MAIDEN NAME Carolyn Ruth Polson	11. BIRTHPLACE (City and state or country) Howard County, Mo.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Jerry Wayne Adams		13b. MOTHER'S MAIDEN NAME Carolyn Ruth Polson	14. NAME OF HUSBAND OR WIFE -----
17. INFORMANT Address Jerry Wayne Adams Fayette, Missouri		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compensated atherosclerosis DUE TO (b) 5 month gestation DUE TO (c) ----- Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
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.) 7625	
20c. TIME OF INJURY Hour a.m. p.m. -----		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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 Fayette, Missouri		21. I attended the deceased from June 1, 1959 to June 1, 1959 and last saw him alive on June 1, 1959 Death occurred at 5:15 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Francis J. Dean M.D.		22b. ADDRESS Fayette, Mo.	
22c. DATE SIGNED 6-13-59		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 6/1/1959		23c. NAME OF CEMETERY OR CREMATORY City Cemetery	
23d. LOCATION (City, town, or county) Fayette, Missouri		24. FUNERAL DIRECTOR Fayal H. Carr	
25. DATE RECD. BY LOCAL REG. 6-13-59		26. REGISTRAR'S SIGNATURE Mary K. Shell	

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, ~~only~~, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Lafayette, Mo.

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.