RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-029753
STATE FILE NUMBER

FILED VS SEP 15 1959

Registration District No. 200 Primary Registration District No. ____ Registrar's No. 147

DED

1. PLACE OF DEATH
a. COUNTY Macon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bevier
Length of stay in 1b —
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Macon
c. CITY OR TOWN Beo.en Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Allen Middle: Thomas Last: Adams

4. DATE OF DEATH Month: 9 Day: 3 Year: 59

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 9-27-70

9. AGE (last birthday): 88
IF UNDER 1 YEAR Months ____ Days ____ IF UNDER 24 HR Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): Charleston, W.Va.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Joshua Adams

13b. MOTHER'S MAIDEN NAME: Sallie McCoy

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Josephine Bradshaw Beo.en Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocarditis	2 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Fractured Hip.	—
DUE TO (c)	Hypostatic Pneumonia	—

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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.)

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

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 February 1959 to 9-3-59 and last saw her/him alive on 8/13/59.
Death occurred at 8:40 A.M. 9-3-59 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Geo. D. Madden M.D.

22b. ADDRESS Macon Mo.

22c. DATE SIGNED 9/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 9-6-59

23c. NAME OF CEMETERY OR CREMATORY E. Oakwood Cem.

23d. LOCATION (City, town, or county) Bevier (State) Mo

24. FUNERAL DIRECTOR ADDRESS D.E. Edwards Bevier Mo

25. DATE RECD. BY LOCAL REG. 9/3/59

26. REGISTRAR'S SIGNATURE Ruth McReely

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed H. G. Edwards

Licensed Embalmer No. 196

P. O. Addres Bruin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.