

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040555**

**FILED VS. NOV 23 1959**

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5574 Registrar's No. 256

ENDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>VanBuren Twp.</b>		Length of stay in 1b <b>70 Years</b>		c. CITY OR TOWN <b>Grainvalley R.F.D.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Buckner-Tarsney Road</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Buckner-Tarsney Road</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Brittie</b> Middle <b>H.</b> Last <b>Adams</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7/8/1889</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Lone Jack Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>John T. Bynum</b>			13b. MOTHER'S MAIDEN NAME <b>Clairissa Clements</b>		14. NAME OF HUSBAND OR WIFE <b>Robert Adams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Robert Adams Grain Valley Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronicus Popliteal Artery, ht.</b>							<b>3 weeks</b>
DUE TO (c)							
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. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 a.m. p.m. Month, Day, Year							
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>20 Dec. 58</u> to <u>11/13/59</u> and last saw <u>her</u> alive on <u>11/13/59</u> . Death occurred at <u>5:00 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>M.D. Duwell M.D.</b>				22b. ADDRESS <b>18E. 3rd St. Lee's Summit, Mo.</b>		22c. DATE SIGNED <b>11/13/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/15/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Adams Cemetery</b>		23d. LOCATION (City, town, or county) <b>So. East Jackson Co. Mo.</b>			(State)
24. FUNERAL DIRECTOR ADDRESS <b>Langsford Funeral Home Lee's Summit Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>11/13/1959</b>		26. REGISTRAR'S SIGNATURE <b>W. Langsford</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 2 1959 SA

**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 W. B. Lingsford

Licensed Embalmer No. 38,333

P. O. Address Leis Summit

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.