

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 6 1960

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STATE FILE NUMBER

Registration District No. 19

Primary Registration District No. _____

Registrar's No. 67

ENDED

1. PLACE OF DEATH a. COUNTY <u>DEKALB</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>ANDREW</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MAYSVILLE</u>		Length of stay in 1b <u>5</u> weeks		c. CITY OR TOWN <u>SAVANNAH</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>603 main Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>JANE</u> Last <u>ADKINS</u>				4. DATE OF DEATH Month <u>December</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-67</u>	
9. AGE (last birthday) <u>92</u>		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) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>ANDREW COUNTY, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>							
13a. FATHER'S NAME <u>PHILLIP BURNS</u>				13b. MOTHER'S MAIDEN NAME <u>unk</u>		14. NAME OF HUSBAND OR WIFE <u>John Frank Adkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT Address <u>Harry Adkins, Savannah, Missouri</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>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 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 checked="" 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>Dec 2, 1959</u> to <u>Dec 21, 1959</u> and last saw her alive on <u>Dec 21, 1959</u> Death occurred at <u>10:50 A. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Spurall Fowler D.C.</u>				22b. ADDRESS <u>Mayville Mo</u>		22c. DATE SIGNED <u>12/22/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>12-21-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SAVANNAH CEMETERY</u>		23d. LOCATION (City, town, or county) <u>SAVANNAH, MISSOURI</u>	
24. FUNERAL DIRECTOR <u>BREIT & HAWKINS</u> ADDRESS <u>SAVANNAH</u>				25. DATE RECD. BY LOCAL REG. <u>12-30-59</u>		26. REGISTRAR'S SIGNATURE <u>Roscoe Davidson</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 James B. Hawkins

Licensed Embalmer No. 4538

P. O. Address Savannah

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.