

# UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN 11 1960

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <b>HOWELL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>HOWELL</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEST PLAINS, MO</b>	Length of stay in 1b <b>78 yrs.</b>	c. CITY OR TOWN <b>WEST PLAINS, MO</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>X</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>440 S. WALKER</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ALICE JOSEPHINE ADAMS</b>			4. DATE OF DEATH Month Day Year <b>12-18-59</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-4-81</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
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>X</b>	11. BIRTHPLACE (City and state or country) <b>WEST PLAINS, MO</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <b>T. F. ADAMS</b>		13b. MOTHER'S MAIDEN NAME <b>EMMA TRANTHAM</b>		14. NAME OF HUSBAND OR WIFE <b>X</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>X</b>	16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT <b>ZONRO ADAMS, SPRINGFIELD, MO</b>	Address <b>X</b>
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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>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerosis/heart</b> DUE TO (c) <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerosis, generalized</b>		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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <b>Arteriosclerosis, generalized</b>
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
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21. I attended the deceased from <b>7-23-54</b> to <b>12-18-59</b> and last saw her live on <b>12-5-59</b> Death occurred at <b>1:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Dr. N. Wiles</b>	(Degree or title)	22b. ADDRESS <b>West Plains, MO</b>	22c. DATE SIGNED <b>1-3-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>	23b. DATE <b>12-20-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>	23d. LOCATION (City, town, or county) <b>WEST PLAINS, MO</b>
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24. FUNERAL DIRECTOR <b>ROBERTSONS, WEST PLAINS, MO</b>	25. DATE RECD. BY LOCAL REG. <b>1-6-60</b>	26. REGISTRAR'S SIGNATURE <b>Beatrice Cook</b>
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(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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*A. A. Roberts*

Licensed Embalmer No. 343

P. O. Address West 72d

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.