

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-015052**

LED VS APR 20 1960

138

Primary Registration District No. 5529

Registrar's No. 16

STATE FILE NUMBER

INDEXED

|   |  |   |  |   |   |  |  |  |         |  |
|---|--|---|--|---|---|--|--|--|---------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hickory</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>                  |   |  |  |  |         |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Wheatland Township</u>                                    |  | Length of stay in 1b <u>12 years</u>  |  | c. CITY OR TOWN <u>Wheatland</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |         |  |
| c. FULL NAME OF (if NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>2 1/2 Miles East of Wheatland</u>               |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   | d. STREET ADDRESS (if outside, give location)<br><u>2 1/2 Miles East of Wheatland</u> |  |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |         |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Thomas</u> Middle <u>Bradrick</u> Last <u>Adee</u>                                |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>11</u> Year <u>1960</u>   |   |  |  |  |         |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>   |  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>Mar 11-90</u>  |  | 9. AGE (last birthday) <u>70</u>   |         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u>                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Wells Kansas</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A</u>  |  | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>0</u> Hours <u>0</u> Min. <u></u>   |         |  |
| 13a. FATHER'S NAME<br><u>Edwin O Adee</u>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>Ada J Bradrick</u>                                   |   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Musie J. Adee</u>                                  |  |  |         |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>             |  |   | 16. SOCIAL SECURITY NO. <u>496-24-0164</u>   |   | 17. INFORMANT<br><u>Ada G. Adee - Hermitage Mo</u>                                    |  |  |  | Address |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:                          |  |   |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |         |  |
| IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>  |  |   |  |   |   |  |  | <u>Immediately</u>   |         |  |
| DUE TO (b) <u>arteriosclerosis</u>  |  |   |  |   |   |  |  | <u>year</u>  |         |  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |         |  |
| 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.)  |   |  |  |  |         |  |
| 20c. TIME OF INJURY<br>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>1956</u> to <u>April 11, 1960</u> and last saw her alive on <u>April 11, 1960</u>             |  |   |  | Death occurred at <u>5:30</u> P on the date stated above, and to the best of my knowledge, from the causes stated.  |   |  |  |  |         |  |
| 22a. SIGNATURE (Degree or title)<br><u>J. E. Briggs, D.O.</u>   |  |   |  | 22b. ADDRESS<br><u>Wheatland, Mo.</u>   |   |  |  | 22c. DATE SIGNED<br><u>4-13-60</u>   |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>4-14-1960</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Robinson Cemetery</u>  |   | 23d. LOCATION (City, town, or county)<br><u>Wheatland, Mo.</u>                       |  | (State)  |         |  |
| 24. FUNERAL DIRECTOR<br><u>Selbert H. Hawley - Wheatland, Mo.</u>   |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>4-13-1960</u>  |   | 26. REGISTRAR'S SIGNATURE<br><u>May Johnson</u>                                      |  |  |         |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

APR 21 1969

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 \_\_\_\_\_

Licensed Embalmer No. 4267

P. O. Address Wheatland, W.

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