

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017848

FILED VS APR 22 1960

INDEXED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1025 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>James Beach</u>		Length of stay in 1b <u>15 yrs.</u>	c. CITY OR TOWN <u>James Beach</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 <u>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John D.</u> Middle <u></u> Last <u>Adkison</u>			4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8, 1899</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>plastic molder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buckhorn Plastic Rolling</u>	11. BIRTHPLACE (City and state or country) <u>Waynesville Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Wm Adkison</u>		13b. MOTHER'S MAIDEN NAME <u>Melissa Gann</u>		14. NAME OF HUSBAND OR WIFE <u>Lily Adkison</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>488-24-7202</u>	17. INFORMANT <u>Lily Adkison</u> Address <u></u>			
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) <u>Terminal pneumonia</u>					<u>4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u>					<u>5 years</u>	
DUE TO (c) <u>Bronchial asthma</u>					<u>Unknown</u>	
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>						
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.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <u>July 1958</u> to <u>3-27-60</u> and last saw him alive on <u>3-26-60</u> Death occurred at <u>1:50 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>H. Johnson D.O.</u> (Degree or title)			22b. ADDRESS <u>Eureka Mo.</u>		22c. DATE SIGNED <u>3/28/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>	23b. DATE <u>Mar 29 '60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Buckhorn Cemetery</u>	23d. LOCATION (City, town, or county) <u>Waynesville</u>	STATE <u>Mo.</u>		
24. FUNERAL DIRECTOR <u>Mrs. John L. Thiebes</u> ADDRESS <u>Lucas Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-28-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>			

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 Ralph Oltmann

Licensed Embalmer No. 4808

P. O. Address Union, Mo.

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.