

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUL 5 1960 042

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60-022344

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b life		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT IN hospital, give location) HOSPITAL OR INSTITUTION 1415 So. 10th St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1415 So. 10th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last ADAMS				4. DATE OF DEATH Month June Day 26 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1936	9. AGE (last birthday) 23	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) driver		10b. KIND OF BUSINESS OR INDUSTRY Bus Company		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William C. Adams			13b. MOTHER'S MAIDEN NAME Anna R. Gibbear		14. NAME OF HUSBAND OR WIFE Patricia Ann Adams		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes 8/17/55 to 12/55		16. SOCIAL SECURITY NO. 487-34-8801		17. INFORMANT Address Mrs. John Adams, 1415 S. 10th, St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO (b) adenocarcinoma gr. iv descending colon DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 5 mos. 13 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). metastatic structure - mild.					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 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 6-10-59 to 6-26-60 and last saw ^{her} him alive on 6-26-60 Death occurred at 10:40 p. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Thompson P. Potter, M.D.				22b. ADDRESS 731 Farson St. St. Joseph, 54, Mo.		22c. DATE SIGNED 6-28-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6/29/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) St. Joseph, Mo.		(State)	
24. FUNERAL DIRECTOR Keaton Bowman			ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. June 30, 1960	26. REGISTRAR'S SIGNATURE Mr. Clark Goodell	

DOCUMENT

BY AFFIDAVIT OF T.E. Potter, M.D. MEDICAL CERTIFICATION

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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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St. Joseph

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.