

FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE
FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-027347

FILED VS AUG 9 1960

STATE FILE NUMBER

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 369

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joplin, Mo.	Length of stay in 1b 1 day	c. CITY OR TOWN Carl Junction	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Saint John's Hosp.		d. STREET ADDRESS 404 So. Main St	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) ADELAIDE ^{First} G. ^{Middle} GREENE ^{Last}		4. DATE OF DEATH 7-24-1960 Day Year	
---	--	---	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1886	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) Teacher	10b. KIND OF BUSINESS OR INDUSTRY Schools	11. BIRTHPLACE (City and state or country) Rock Island, Ill	12. CITIZEN OF WHAT COUNTRY USA
---	---	---	---

13a. FATHER'S NAME Jim Johnston	13b. MOTHER'S MAIDEN NAME Annie Gray	14. NAME OF HUSBAND OR WIFE
---	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT Mrs. Leslie Anderson, Okla City, OK Address
--	----------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 2-28-48
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	7-24-60
	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 checked="" 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 Month, Day, Year a.m. p.m.	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 2-28-48 to 7-24-60 and last saw her ^{him} alive on 7-24-60 Death occurred at 4:40 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J. R. Kuhn, Jr.</i> (Degree or title) J. R. Kuhn, Jr. M.D.	22b. ADDRESS 321 Frisco Bldg., Joplin, Mo.	22c. DATE SIGNED 8-2-60
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-26-1960	23c. NAME OF CEMETERY OR CREMATORY Carl Junction, Mo.	23d. LOCATION (City, town, or county) (State) Carl Junction, Mo.
--	-------------------------------	---	--

24. FUNERAL DIRECTOR Don Roney, Carl Junction, Mo. ADDRESS	25. DATE WHEN BY LOCAL REG. 8-4-1960	26. REGISTRAR'S SIGNATURE <i>Nove Merriam</i>
--	--	--

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 Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address Webb City, Mo.

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