IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS JUL 2 9 1960

-60-029302
STATE FILE NUMBER

NDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 179

1. PLACE OF DEATH
a. COUNTY: Scott
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Sikeston
Length of stay in 1b: 2 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Mo. Delta Comm. Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Mississippi
c. CITY OR TOWN: Charleston
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Rt. #3, Box 20
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First ALBERT Middle Last ADKINS
4. DATE OF DEATH: Month 7 Day 21 Year 1960
5. SEX: Male
6. COLOR OR RACE: negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 1858
9. AGE (last birthday): 102
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): Farm Hand
10b. KIND OF BUSINESS OR INDUSTRY: Farm Hand
11. BIRTHPLACE (City and state or country): Unkown
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Green Adkins
13b. MOTHER'S MAIDEN NAME: Mary ?
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Leonard Adkins Address: Rt 3 Box 20 Charleston Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

7.18.60 7.21.60

21. I attended the deceased from 7.18.60 to 7.21.60 and last saw him alive on 7.21.60
Death occurred at 9:40 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carl G. Topp M.D.
22b. ADDRESS: Sikeston, Mo.
22c. DATE SIGNED: 7.22.60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 7/25/60
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove
23d. LOCATION (City, town, or county) (State): Charleston Mo.

24. FUNERAL DIRECTOR: Peoples Funeral Home ADDRESS: 628 W. Marshall Charleston Mo.
25. DATE RECD. BY LOCAL REG.: 7-23-60
26. REGISTRAR'S SIGNATURE: Mrs Ellen Hunter

BY AFFIDAVIT OF: DOCUMENT

(Licensed Embalmer's Statement on Reverse Side)

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 Mabel L. Donaldso

Licensed Embalmer No. 509

P. O. Address 626 W. Marsha
Charleston Mo.

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