JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960

60-031803

STATE FILE NUMBER

NDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7939

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b: 25 Yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1485 Laurel
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Jessie Middle: Christine Last: Adams

4. DATE OF DEATH: Month: 8 Day: 8 Year: 60

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]

8. DATE OF BIRTH: 10/3/1895

9. AGE (last birthday): 64

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): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: DOMESTICTS

11. BIRTHPLACE (City and state or country): SIKESTON MISSOURI

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: SAM WALKER

13b. MOTHER'S MAIDEN NAME: ANNA TERRELL

14. NAME OF HUSBAND OR WIFE: EXELLE ADAMS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 332-18-1399

17. INFORMANT: Mrs. CLYDE WALKER Address: 4525, ST LOUIS Ave.

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 Thrombosis
INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 332x

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 [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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

21. I attended the deceased from 8-1-60, to 8-8-60 and last saw her/him alive on 8-8-60
Death occurred at 7:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sydney A. Hall (Degree or title): M. D.

22b. ADDRESS: 2601 N. Whittier St.

22c. DATE SIGNED: 8-8-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 8/15/60

23c. NAME OF CEMETERY OR CREMATORY: GREENWOOD CEMETERY

23d. LOCATION (City, town, or county) (State): ST. LOUIS. MISSOURI

24. FUNERAL DIRECTOR: John L. Houston ADDRESS: 2812 THOMAS ST.

25. DATE RECD. BY LOCAL REG.: AUG 11 1960

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 44

P. O. Address 2812 Ale

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.