RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

530160-038244
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. 5301

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 50 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4123 Independence
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 4843 E 7 ST.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: CLINTON Middle: Last: Adams
4. DATE OF DEATH Month Day Year: October 22, 1960
5. SEX: Male
6. COLOR OR RACE: Cauc.
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Jan. 9, 1887
9. AGE (last birthday): 73
IF UNDER 1 YEAR / IF UNDER 24 HR: Months | Days | Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boilermaker
10b. KIND OF BUSINESS OR INDUSTRY: Building Trades
11. BIRTHPLACE (City and state or country): Colby Kansas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Joner Adams
13b. MOTHER'S MAIDEN NAME: Lavina Scott
14. NAME OF HUSBAND OR WIFE: Delcena Adams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 490-09-2005
17. INFORMANT: Delcena Adams Address: 4843 E 7 ST.

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)	Coronary thrombosis	few minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Rectal hemorrhage	6 mons.
DUE TO (c)	Rectal cancer	3 yrs.

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

21. I attended the deceased from 6/7/60 to 10/22/60 and last saw ~~him~~ alive on 10/18/60
Death occurred at Kelly Nursing Home 8:30 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE T. E. Van Buskirk (Degree or title) M.D.
22b. ADDRESS 5246 St. John K.C. Mo
22c. DATE SIGNED 10/24/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Oct. 24, 1960
23c. NAME OF CEMETERY OR CREMATORY: Dennard Cemetery
23d. LOCATION (City, town, or county) (State): Dennard Arkansas
24. FUNERAL DIRECTOR: Muehlebach ADDRESS: 6500 Troost
25. DATE RECD. BY LOCAL REG.: 10-22-60
26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF T. E. Van Buskirk MEDICAL CERTIFICATION

DOCUMENT

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 R. E. Nichols
Signature of Student Embalmer

Licensed Embalmer No. 4[illegible]

P.O. Address K.C.

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