

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001100

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 22

AMENDED

FILED VS FEB 14 1961

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in 1b <u>3 day</u>	c. CITY OR TOWN <u>Sugar Creek Twp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nall Mem. Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>Gilman City Rural</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Donald Wayne Adams</u>			4. DATE OF DEATH Month Day Year <u>2-8-1961</u>		
--	--	--	--	--	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-60</u>	9. AGE (last birthday) <u>0</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>
--------------------	-------------------------------	--	--------------------------------	---------------------------------	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Harrison Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
---	---	--	---

13a. FATHER'S NAME <u>Wade Adams</u>	13b. MOTHER'S MAIDEN NAME <u>Nora Mervigan</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
--------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Wade Adams Gilman City Mo</u>
--	-------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last:	DUE TO (b) <u>Hemorrhagic Gastroenteritis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) <u>Anemia (Iron Deficiency)</u>		DUE TO (c)

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.)	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
--	---	---	--

20c. TIME OF INJURY Hour <u>6:55 p.m.</u> Month, Day, Year <u>2-5-61</u>	20d. INJURY OCCURRED 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 <u>2-5-61</u> to <u>2-8-61</u> and last saw <u>him</u> alive on <u>2-8-61</u> Death occurred at <u>6:55 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
---	--	--

22a. SIGNATURE: (Degree or title) <u>Albert Hibbe M.D.</u>	22b. ADDRESS <u>Bethany, Mo.</u>	22c. DATE SIGNED <u>2-10-61</u>
--	----------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-10-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Johns</u>	23d. LOCATION (City, town, or county) (State) <u>Gilman City Mo.</u>
---	--------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>MBS Haas Bethany Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-10-1961</u>	26. REGISTRAR'S SIGNATURE <u>Gella Masey</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed MB Haas

Licensed Embalmer No. 3899

P. O. Address Bethany Mo

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.