

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-002288

FILED VS JAN 12 1961

AMENDED

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. 1

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Mississippi</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Miss.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Charleston</b>	Length of stay in 1b <b>5 yrs</b>	c. CITY OR TOWN <b>Charleston</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1006 State</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1006 State</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>( NONE )</b> Last <b>Adams</b>	4. DATE OF DEATH Month <b>1</b> Day <b>3</b> Year <b>1961</b>
---	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-5-1883</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
----------------------	-------------------------------	--	----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Charleston, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	--	--	--

13a. FATHER'S NAME <b>Robert Snyder</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Huffman</b>	14. NAME OF HUSBAND OR WIFE <b>Guy Adams (dec'd)</b>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Don Adams, 1006 State, Charleston Mo.</b>
--	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Atherosclerosis</b>	<b>?</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) <b>Diabetes</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 <b>9:30</b> Month, Day, Year	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 <b>May 29, 1959</b> to <b>January 3, 1961</b> and last saw her <b>him</b> alive on <b>January 3, 1961</b> Death occurred at <b>9:30</b> <b>A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>Don Adams</b>	22b. ADDRESS <b>Charleston, Mo.</b>	22c. DATE SIGNED <b>1-4-61</b>
---	-------------------------------------	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-6-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery near Charleston, Illinois</b>	23d. LOCATION (City, town, or county) (State)
---	---------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <b>THE NUNNELEE FUNERAL CHAPEL, Charleston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-6-61</b>	26. REGISTRAR'S SIGNATURE <b>Dorothy B. Hutton</b>
--	--	--

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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

*John F. Munnell Jr.*

Licensed Embalmer No.

3851

P. O. Address

Charleston, 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.