

**MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-020905**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 547

STATE FILE NUMBER

AMENDED FILED JUL 11 1961

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
Length of stay in 1b		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>Handley Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1447 N Rogers St.</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>J</u> Middle <u>Walter</u> Last <u>Adams</u>			4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 29, 1873</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Greene Co Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James W Adams</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Johnson</u>	
14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs Howard Duncan, 1312 E Division</u>		Address			

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>Cardio Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m.	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 <u>Springfield, Mo</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>April 1961</u> to <u>May 31, 1961</u> and last saw her/him alive on <u>May 31, 1961</u>		Death occurred at <u>4:45</u> <u>Pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>Lyman D Brown, M.D.</u>	(Degree or title)	22b. ADDRESS <u>311 1/2 College Spfld Mo</u>	22c. DATE SIGNED <u>6-16-61</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u>	23b. DATE <u>June 3, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo</u>

24. FUNERAL DIRECTOR <u>H.V. Smith, 602 N Jefferson, Spfld Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-2-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

1961 JUL 17 SA

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.