

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-024947

STATE FILE NUMBER

AMENDED

Registration District No.

140

Primary Registration District No.

3024

Registrar's No.

76

FILED JUL 31 1961

1. PLACE OF DEATH

a. COUNTY

Howard

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Fayette

Length of stay in 1b

2 days

c. FULL NAME OF (If not in hospital, give location)
HOSPITAL OR INSTITUTION

Lee Hospital

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

admission)

c. CITY

OR TOWN

Missouri Montgomery

Wellsville

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Elizabeth L. Adams

4. DATE OF DEATH

Month

Day

Year

July 19, 1961

SEX

6. COLOR OR RACE

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

Female

White

Jan 21, 1903

58

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTH PLACE (City and state or country)

Glasgow Mo.

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13a. FATHER'S NAME

James Lewis

13b. MOTHER'S MAIDEN NAME

May Sgleheart

14. NAME OF HUSBAND OR WIFE

Fred A. Adams (de)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no (month/year)) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

499-44-8576

17. INFORMANT

Mrs. Lee Harrison Glasgow Mo

Address

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

20 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Chronic Arteriosclerosis

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.

☐ Yes ☒ No ☐ Unknown19. 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

Month, Day, Year

a.m.

p.m.

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 7-18-61 to 7-19-61 and last saw her alive on 7-19-61
Death occurred at 8:05 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

W. S. S.

22b. ADDRESS

Fayette Mo

22c. DATE SIGNED

7-25-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

Burial

July 21, 1961

City Cemetery

Wellsville Mo.

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Wells Funeral Home Wellsville Mo

7-25-61

Katherine Welch

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

APR 17 1962

JAN 15 1963

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 Ed Hiernmont

Licensed Embalmer No. 3978

P. O. Address Glasgow, 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.