

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040659

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. Allison

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1160

STATE FILE NUMBER

FILED DEC 4 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MISSOURI b. COUNTY GREENE			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD			Length of stay in 1b 55 YRS.		c. CITY OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2013 W. OLIVE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IDA Middle M. Last ADAMS			4. DATE OF DEATH Month NOV. Day 26 Year 1961				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/20/89	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR 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		11. BIRTHPLACE (City and state or country) EUREKA SPRINGS, ARK.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JONES			13b. MOTHER'S MAIDEN NAME CLARA REDFERN		14. NAME OF HUSBAND OR WIFE DAVID F. ADAMS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Address DAVID F. ADAMS, SPRINGFIELD, MO.			
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>Myocardial infarction</u> 25 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary artery atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" 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 Month, Day, Year a.m. p.m.							
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 <u>Wed Nov 22nd</u> to <u>Nov 24th</u> and last saw her/him alive on <u>Nov 24 at 9:00 PM</u> Death occurred at <u>1:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>[Signature]</i> MD				22b. ADDRESS <u>1636 E. Glenstone Springfield Mo</u>		22c. DATE SIGNED <u>11/29/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 11/29/61		23c. NAME OF CEMETERY OR CREMATORY GREENLAWN		23d. LOCATION (City, town, or county) SPRINGFIELD, MO.	
24. FUNERAL DIRECTOR H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.				25. DATE RECD. BY LOCAL REG. <u>11-29-61</u>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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 *W. J. McCarroll*

Licensed Embalmer No. 2727

P. O. Address *Spencer, Va.*

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.