

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-81-041550
STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 196

AMENDED

FILED NOV 21 1961

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		Length of stay in lb <u>10 yrs.</u>	c. CITY OR TOWN <u>Lebanon</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>Louise G. Wallace</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>232 Washington Court</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Horace Wilmot Adams</u>			4. DATE OF DEATH Month Day Year <u>Nov. 13, 1961</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-16-89</u>
9. AGE (last birthday) <u>72</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Govt. employe</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	11. BIRTHPLACE (City and state or country) <u>Bonne Terre, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Rev. Franklin Adams</u>	
13b. MOTHER'S MAIDEN NAME <u>Eliza Casey</u>		14. NAME OF HUSBAND OR WIFE <u>Beulah L. Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I</u>		16. SOCIAL SECURITY NO. <u>500-36-6046</u>	17. INFORMANT Address <u>Mrs. Beulah L. Adams, Lebanon, 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>Wremia</u> DUE TO (b) <u>Chronic glomerulonephritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years.</u>
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 checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>None</u>		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	COUNTY STATE
21. I attended the deceased from <u>3/7/52</u> to <u>11/13/61</u> and last saw ^{her} him alive on <u>11/13/61</u> Death occurred at <u>12:05 a.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>George E. Fisher M.D.</u>		22b. ADDRESS <u>Lebanon, Mo</u>	22c. DATE SIGNED <u>11/13/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11-15-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) (state) <u>Lebanon, Laclede Co., Mo.</u>
24. FUNERAL DIRECTOR <u>J. J. Shadel</u>		ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-14-1961</u>
		26. REGISTRAR'S SIGNATURE <u>Beulah L. Adams</u>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

DEC 12 1961

NOV 22 1961

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. 5115

P. O. Address Springfield

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.