

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030580

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 127Primary Registration District No. 2000Registrar's No. 12949

STATE FILE NUMBER

FILED AUG 31 1962

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield</u>		Length of stay in 1b <u>1 Day</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>Rural</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEO</u> Middle <u>GEORGE</u> Last <u>ADAMS</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>24</u> Year <u>1962</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>8/26/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (last birthday) <u>73</u>
11a. FATHER'S NAME <u>Charles Adams</u>		11b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	11. BIRTHPLACE (City and state or country) <u>Streator, Ill.</u>
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		13. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
14. NAME OF HUSBAND OR WIFE <u>Mrs. Maire Adams</u>		15. INFORMANT <u>Lester Adams, Willow Springs, Mo.</u>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart disease</u> 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) <u>Recent Cerebral Hemorrhage</u> 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"/>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)	
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.)	
21. I attended the deceased from <u>8-23-62</u> to <u>8/24/62</u> and last saw her/him alive on <u>8-23-62</u> Death occurred at <u>7:10 A.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Dr. T.E. Ferrell, M.D.</u>	
22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>8-29-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/27/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>City</u>		23d. LOCATION (City, town, or county) (State) <u>Willow Springs, Mo.</u>	
24. FUNERAL DIRECTOR <u>Burns, Willow Springs, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8-30-62</u>	
26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/5910397246034 05 167 18 294200101112 4-013

Permit
8-24-62

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 _____ Signed L. Doolin Gorman
Signature of Student Embalmer

Licensed Embalmer No. 3177
P. O. Address Springfield, 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.