

Dr. Fitch
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-019672

STATE FILE NUMBER

DO NOT WRITE
ON THIS SUB

AMENDED

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 778

FILED MAY 27 1963

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 70 YRS.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP.		Inside Limits Yes ☒ No ☐	
d. STREET ADDRESS 1200 E. DELMAR		(If outside, give location) Reside on Farm Yes ☐ No ☒	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last ADAMS		4. DATE OF DEATH Month MAY Day 20 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH 7/27/70
9. AGE (last birthday) 92		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) KANSAS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JACK J. BLUE		13b. MOTHER'S MAIDEN NAME ORIE GILLESPIE	
14. NAME OF HUSBAND OR WIFE FRANK ADAMS (DEC.)			
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 MRS. PEARL JENNINGS, SPRINGFIELD, MO.		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) Cardio Renal Vascular Disease DUE TO (b) DUE TO (c)		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. ☐ Yes ☐ No ☐ Unknown	
19. 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 a.m. p.m. Month, Day, Year			
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 4-22-63 to 5-24-63 and last saw her alive on 5-19-63 Death occurred at 4:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Max Fitch M.D.		22b. ADDRESS 1715 BOONVILLE SPRINGFIELD MISSOURI	22c. DATE SIGNED 5-22-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5/22/63	23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MO.
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. 5-24-63	26. REGISTRAR'S SIGNATURE Effie L. Melton ew

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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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 Lucien T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield, Ma

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.

Permit 5-24-63