

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-029645

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7820 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB AMENDED

**FILED AUG 9 1963**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b <b>1 week</b>	c. CITY OR TOWN <b>Sparta</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Randolph</b>		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>817 No. St. Louis St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>PEARL M. ADAMS</b>			4. DATE OF DEATH Month Day Year <b>JULY 30 1963</b>		5. SEX <b>Female</b>		
6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5/8/1895</b>		9. AGE (last birthday) <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>		11. BIRTHPLACE (City and state or country) <b>Ava, Illinois.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Anderson Schellenger</b>			13b. MOTHER'S MAIDEN NAME <b>Ella Brownfield</b>		14. NAME OF HUSBAND OR WIFE <b>Frank W. Adams</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address <b>Mrs. Charles Crouch, Sparta, Ill.</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
DUE TO (b) <b>PERFORATION OF TERMINAL ILEUM, ETIOLOGY UNK.</b>							<b>7 days</b>
DUE TO (c) <b>578X</b>							
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 checked="" type="checkbox"/> NO <input 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 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>12/16/54</u> , to <u>7/30/63</u> and last saw her <sup>her</sup> <del>her</del> alive on <u>7/30/63</u> Death occurred at <u>10:55 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>C. D. Vermillion, M.D.</i> M.D.				22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>7/31/63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-2-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Caledonia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sparta, Ill.</b>		
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 31 1963</b>		26. REGISTRAR'S SIGNATURE <i>Loal Smith, M.D.</i>		

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USE BLACK INK OR TYPEWRITER RIBBON

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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 Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.