

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047786

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 322

FILED DEC 23 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>BENTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>7 day</u>	c. CITY OR TOWN <u>WARSAW</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wetzel Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>_____</u>
3. NAME OF DECEASED (Type or print) First <u>STEPHEN</u> Middle <u>B.</u> Last <u>ADAMS</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rt. Grocery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eldon, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Elijah Adams</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Keys</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>564-20-8846</u>	
17. INFORMANT <u>William R. Adams</u>		Address <u>Box 36 Shawnee Lake, Calif</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>Myocardial Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Infection & Debilitation</u>			<u>10 days</u>
DUE TO (c) <u>Cerebral Thrombosis</u>			<u>12 days</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"/>	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>12-8-63</u> to <u>12-15-63</u> and last saw her/him alive on <u>12/15/63</u> Death occurred at <u>5:28 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Clinton L. Glasgow</u> (Degree or title)		22b. ADDRESS <u>Clinton, Mo.</u>	22c. DATE SIGNED <u>12/15/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 17, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City, town, or county) <u>Eldon Miller Co, Mo</u>
24. FUNERAL DIRECTOR <u>John F Reser</u> ADDRESS <u>Warsaw</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 17, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Biggers</u>

USE BLACK INK OR TYPEWRITER RIBBON

APR 29 1966

JAN 7 1964

JAN 23 1964

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 John F. Reser

Licensed Embalmer No. 4098
P. O. Address Warsaw

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.

335X

Permit Obtained 12-19-65

(M.S.)