

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14851

State File No.

FILED MAY 16 1949

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 498

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Mo</u> b. COUNTY <u>Platte</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Edgerton</u>	
c. LENGTH OF STAY (in this place) <u>3 yrs 8 mos 2 wks</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Hospital #2</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Thomas</u>	b. (Middle) <u>Francis</u>	c. (Last) <u>Adams</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 1 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>Dec 28 1914</u>	9. AGE (In years last birthday) <u>34</u>	# UNDER 1 YEAR Months <u>4</u> Days <u>13</u>	# UNDER 24 HRS. Hours <u>13</u> Min. _____
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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>Firm</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Adams</u>	13b. MOTHER'S MAIDEN NAME <u>Mary M. Pulliam</u>	14. NAME OF HUSBAND OR WIFE <u>Single</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>unk.</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records Hospital</u> ADDRESS <u>Frank</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Vascular Syphilis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Syphilis</u>		c53x	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 1945, to 5-1-1949, 19____, that I last saw the deceased alive on May 1, 1949, and that death occurred at 4:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE BY <u>Dr. Salzer</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>St. Joseph Mo State Hospital #2</u>	23c. DATE SIGNED <u>5-1-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/3/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hearborn, Mo</u>	24d. LOCATION (City, town, or county) (State) <u>Mo</u>
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DATE REC'D BY LOCAL REG <u>May 2, 1949</u>	REGISTRAR'S SIGNATURE <u>E. K. Jenkins</u>	52	25. FUNERAL DIRECTOR'S SIGNATURE <u>Pulliam & Frank Edgerton</u> ADDRESS <u>Mo</u>
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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.

Signed _____

Virian Rollins Gash

Signed.....
Student Embalmer

Licensed Embalmer No. _____

3947

P. O. Address _____

Edgerton 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 this body is not embalmed, fact should be so stated above.