

FILED DEC 9 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40014

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 365 PRIMARY REG. DIST. NO. 4634 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Caledonia mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Caledonia</u> <u>110</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>2</u>	
3. NAME OF DECEASED a. (First) <u>Joseph</u> b. (Middle) <u>William</u> c. (Last) <u>Adams</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 21 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 8 1869</u>
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>	IF UNDER 4 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Fabrics</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Belgrade mo. T</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Daniel Adams</u>	13b. MOTHER'S MAIDEN NAME <u>Hattie Maxwell</u>	14. NAME OF HUSBAND OR WIFE <u>May E. Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT'S SIGNATURE OR NAME <u>May E. Adams</u> ADDRESS <u>Caledonia mo.</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Chronic Bronchitis</u> <u>4 years</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Fall on back and neck.</u> <u>2 days</u> 2. OTHER SIGNIFICANT CONDITIONS** Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterio Sclerosis C. 1000</u> <u>4 years</u>	
19a. DATE OF OPERATION <u>-</u>	19b. MAJOR FINDINGS OF OPERATION <u>-</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>-</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Caledonia Washington Mo.</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11-19-49 5:58 p.m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell off 3rd step from ground.</u>	
22. I hereby certify that I attended the deceased from <u>11-19</u> , 1949, to <u>11-21</u> , 1949, that I last saw the deceased alive on <u>11-21</u> , 1949, and that death occurred at <u>8:10 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Joseph L. Flurman M.D.</u>		23b. ADDRESS <u>Potosi, Mo.</u>	23c. DATE SIGNED <u>11-25-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-23-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian</u>	24d. LOCATION (City, town, or county) (State) <u>Caledonia Mo.</u>
DATE REC'D BY LOCAL REG. <u>11 29-49</u>	REGISTRAR'S SIGNATURE <u>Ella D. White</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mr. Luther Sparks Potosi Mo.</u>	

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

1 10

12-2-49

Health Officer No. 4  
File Number 1249-1565  
Date Filed \_\_\_\_\_

SEP 8 1953

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 .....  
Student Embalmer

Signed Murphy L. Spore

Licensed Embalmer No. 4236

P. O. Address St. Martin Ave

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.