

FILED DEC 3 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39743

STATE FILE NUMBER

Registration District No. 96 Primary Registration District No. 5351 Registrar's No. 94

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Miller</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Buffalo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Celt, Mo</u>			Length of stay in 1b <u>12 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>Celt, Mo.</u>		Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>-</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26, 1869</u>		9. AGE (In years last birthday) <u>88</u>	10. IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	11. IF UNDER 24 HRS. Hours <u>18</u> Min. <u>24</u>
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>-</u>		11. BIRTHPLACE (City and state or country) <u>Miller County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Benjamin Adams</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Minnie Adams</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Fred Adams</u> Address <u>Celt, Mo.</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>Cerebral Hemorrhage (Apoplexy)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>							20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Psychosis</u>							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.) <u>331X</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			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 <u>Buffalo</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>					
21. I attended the deceased from <u>11-23-57</u> to <u>11-24-57</u> and last saw him alive on <u>11-24-57</u> . Death occurred at <u>3:10 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>O.O. Jamison</u> (Degree or title) <u>M.D.</u>			22b. ADDRESS <u>Buffalo Mo.</u>			22c. DATE SIGNED <u>11-26-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11/27/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hope Well Cem</u>			23d. LOCATION (City, town, or county) (State) <u>Dallas County, Mo.</u>		
24. FUNERAL DIRECTOR <u>Montgomery Funeral Home</u> ADDRESS <u>Buffalo, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12/2/57</u>		26. REGISTRAR'S SIGNATURE <u>Mrs Grace Petree</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

JAN 12 1959

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 *Leijde Montgomery*

Licensed Embalmer No. *3592*

P. O. Address *Buffalo, 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.