

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028693

FILED VS AUG 24 1959 *728*

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. *2000* Registrar's No. *872*

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Greene</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dade</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Springfield, Mo.</b>	Length of stay in 1b <b>4 weeks</b>	c. CITY OR TOWN <b>Dadeville</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>South part of town</b>

<b>3. NAME OF DECEASED</b> First Middle Last <b>LAWRENCE GRANT ADAMS</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>Aug. 18 1959</b>		
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<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan. 6, 1909</b>	<b>9. AGE (last birthday)</b> <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Bus Driver</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Cedar Co., Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>
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<b>13a. FATHER'S NAME</b> <b>Charles F. Adams</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Effie Jane Brown</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Melba Adams</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>	<b>16. SOCIAL SECURITY NO.</b> <b>488-16-1748</b>	<b>17. INFORMANT</b> Address <b>Melba Adams, Dadeville, Mo.</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Peritonitis, Generalized</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Perforation of Large Bowel</b> DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes Mellitus</b>		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	
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)		
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<b>20c. TIME OF INJURY</b>	Hour a.m. p.m.	Month, Day, Year
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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**21.** I attended the deceased from **6-17-59** to **8/18/59** and last saw <sup>her</sup>him alive on **8-18-59**  
 Death occurred at **12:55** **a.**m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>W. J. Dard, M.D.</b>	<b>22b. ADDRESS</b> <b>609 Cherry, Springfield, Mo.</b>	<b>22c. DATE SIGNED</b> <b>8/18/59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>8/20/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Dadeville Masonic</b>	<b>23d. LOCATION</b> (City, town, & county) (State) <b>Dadeville, Dade, Missouri</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>J. C. Canada Greenfield, Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-20-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Effie G. Meeter</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FORM 93 1901

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Lee Mason

Licensed Embalmer No. 4568

P. O. Address Springfield

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.