

FEDERAL BUREAU OF INVESTIGATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 5 1960

=60-022766

STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 147

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|--|--|---|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Franklin | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Franklin | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Washington Mo. | | Length of stay in 1b 10 days | | c. CITY OR TOWN Sullivan Mo. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hospital | | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Division St. | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bertie Eastman Adams | | | | 4. DATE OF DEATH Month Day Year June 28 1960 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 6-6-1896 | | |
| 9. AGE (last birthday) 64 | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HR. Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (City and state or country) Salem Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME William Eastman | | | 13b. MOTHER'S MAIDEN NAME Emma Whiteaker | | | 14. NAME OF HUSBAND OR WIFE George Adams | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none | | | 16. SOCIAL SECURITY NO. 500-28-9643 | | 17. INFORMANT George Adams Sullivan Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| DUE TO (b) Arteriosclerosis - thrombotic | | | | | | | Unknown | |
| DUE TO (c) | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus Coronary Arteriosclerosis | | | | | | | 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 checked="" type="checkbox"/> NO <input 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 1953 to 1960 and last saw her ^{her} alive on June 28-1960 Death occurred at 8:30 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Robert J. Shaffer M.D. | | | | 22b. ADDRESS Sullivan, Missouri | | | 22c. DATE SIGNED June 29, 1960 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-1-1960 | 23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. | | 23d. LOCATION (City, town, or county) (State) Sullivan Mo. | | | |
| 24. FUNERAL DIRECTOR Thos. P. Shaffer Sullivan Mo. | | | | 25. DATE RECD BY LOCAL REG. 6/29/60 | | 26. REGISTRAR'S SIGNATURE J.P. Schumann | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Geo. P. Shaffer

Licensed Embalmer No. 2692

P. O. Address Sullivan

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.