

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035438

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 330

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 8 1962

1. PLACE OF DEATH a. COUNTY <b>MARION</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MARION</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HANNIBAL</b>		Length of stay in 1b <b>1 Month</b>	c. CITY OR TOWN <b>MONROE CITY</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. ELIZABETH HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>708 N. MAIN ST</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FOUNTIE M. ADAMS</b>			4. DATE OF DEATH Month Day Year <b>SEPTEMBER 18, 1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7, 1897</b>
9. AGE (last birthday) <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (City and state or country) <b>TRIPPLET, MISSOURI</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN BARNES</b>	
13b. MOTHER'S MAIDEN NAME <b>ELIZA BLOCKMAN</b>		14. NAME OF HUSBAND OR WIFE <b>SAM E. ADAMS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Sam E Adams Monroe City Mo</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Septicemia &amp; toxemia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>multiple abd. abscesses</b> DUE TO (c) <b>acute pancreatitis from obstructed pancreatic duct from gall stones</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 weeks</b> <b>6 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 <b>3 AM 8/9/62</b> to <b>9/18/62</b> and last saw her alive on <b>9/18/62</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Ron Strong MD</b> (Degree or title)		22b. ADDRESS <b>Hannibal Mo</b>	22c. DATE SIGNED <b>9/18/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT 20, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St JUDES CEMETERY</b>	23d. LOCATION (City, town, or county) <b>MONROE CITY, MISSOURI</b>
24. FUNERAL DIRECTOR <b>Wilson &amp; Son's</b> ADDRESS <b>Monroe City Mo</b>		25. DATE RECD. BY LOCAL REG. <b>Sept 19, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. Maluckes by Lillian M. Berman</b>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

VS 300 Rev. 4/59  
**0678**  
**20648**  
3  
4 **1**  
5 **1**  
6  
7 **0**  
8 **1**  
9 **5841X0**  
10  
11  
12 **2-0**  
13 **1-0**

USE BLACK INK OR TYPEWRITER RIBBON

**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 me, Student Embalmer No. \_\_\_\_\_,  
working under my personal supervision.

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

Signed Leslie L. Wilson

Licensed Embalmer No. 3014

P. O. Address Monroeville, Pa

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.

Permit renewed 9/19/62