

REC'D FEB 20 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1125

Do not use this space.

1. PLACE OF DEATH

(a) County.....**Jackson**..... Registration District No. **399**
(b) Township.....**Kaw**..... Primary Registration District No. **1002** Registered No. **138**
(c) City.....**Kansas City, Mo.**..... (d) Street No. **Northeast Hospital, K.C. Mo.**..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

352 **Jack Dudley Adams,**
(a) Residence, No. **2247 Garfield A venue, K.C. Kansas. s.t.** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX **Male**
4. COLOR OR RACE **White**
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Single**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 10th, 1939**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF -----

22. I HEREBY CERTIFY, That I attended deceased from **1-3-** 19**39** to **1-10-** 19**39**6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **October 20th, 1921**I last saw h. **in** alive on **1-10-** 19**39** Death is said to have occurred on the date stated above, at **2:35 A.M.**
The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
10 2 20

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **Boy Child**
10. Date deceased last worked at this occupation (month and year).....
11. Total time (years) spent in this occupation.....

Tuberc. Pneumonia Date of onset12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **K. C. Mo.**

Other contributory causes of importance:

Post operative one week appendicitis from gangrenous appendix13. NAME **Walter L. Adams,**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri**Name of operation **appendectomy** Date of **1-10-39**
What test confirmed diagnosis? **Tub.** Was there an autopsy? **10**15. MAIDEN NAME **Ernie D. Seiger**23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Kansas.**17. INFORMANT **Walter L. Adams,**
(ADDRESS) **1200 North Liberty, Indp. Mo.**18. BURIAL, CREMATION, OR REMOVAL PLACE **Mt. Moriah, Cem.** DATE **Jan. 12th, 1939**19. FUNERAL DIRECTOR (NAME) **Mrs. C.L. Forster**
(ADDRESS) **918 Brooklyn Avenue, K.C. Mo.**20. FILED **Jan 12 1939 M.M. Brown**
Local Registrar.24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify.....(Signed) **Dr. Frank E. Heed**, M. D.
(Address) **3600 Harrison**

3600 Kaminium

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

..... Licensed Embalmer No.....

..... P. O. Address.....

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, above space should be left blank.