

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 24 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

11494

Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 529505
 (b) Township Chariton Primary Registration District No. 5700 Registered No. _____
 (c) City _____ (d) Street No. _____
 (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. da. (f) How long in U. S., if of foreign birth? _____ yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 325 James Collins St. ☐ (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 15, 1853
 7. AGE YEARS 86 MONTHS 1 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

13. NAME Josh Adkins

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Wade Peter
(ADDRESS) R R 4 exels mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Peter Cem DATE Mar 24 1939

19. FUNERAL DIRECTOR (NAME) Albert Skinner
(ADDRESS) Macon mo 473

20. FILED April 19 1939 Mrs R. W. Dowell
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 21, 1939, to March 22, 1939.
 I last saw him alive on March 22, 1939. Death is said to have occurred on the date stated above, at 9 A m.
 The principal cause of death and related causes of importance were as follows:

Sarcoma of Prostate

Date of onset

Other contributory causes of importance: 51

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. L. Shippee, M. D.

(Address) College mound mo

STATEMENT TO BE FILED WITH THE
CERTIFICATE OF DEATH
ISSUED BY THE HEALTH OFFICER

RECEIVED

RECEIVED

District Health Officer No. 10

District File Number 10-39-624

Date Filed APR 19 1939

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.