DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34969

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3944

OCT NOV 14 1939

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K C Gen Hosp. No 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether

In this community 65 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. Dixon Hotel (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Robert K Adams 552

3. (b) If veteran, name war Unk

3. (c) Social Security No. Unk

4. Sex M

5. Color or race Wh

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Unk — (Month) (Day) (Year)

8. AGE: Years 86 Months — Days — If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Ky (State or foreign country)

10. Usual occupation Electrical wrk

11. Industry or business

FATHER
12. Name Wm H. Adams
13. Birthplace ..... (City, town, or county) Ky (State or foreign country)

MOTHER
14. Maiden name Louisa Humble
15. Birthplace ..... (City, town, or county) Ky (State or foreign country)

16. (a) Informant's own signature Ellen Adams

(b) Address Dixon Hotel

17. (a) Forest Hill (Burial, cremation, or removal) (b) Date thereof 10-14-39 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director W. J. Mayberry

(b) Address 2315 Linwood

19. (a) 10-13-39 (Date received local registrar) (b) Mmlawn (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11 year 1939 hour 6 minute 10 a M.

21. I hereby certify that I attended the deceased from Oct 8, 1939 to Oct 11th, 1939 that I last saw him alive on Oct 11, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death Right Frontal Brain Tumor

Due to 53

Due to

Other conditions Bilateral Influent Bronchopneumonia (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature P F DeMaria M.D. (M.D. or other)

Address Supt K C Gen Hosp Date signed 10-14-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 1 X19311

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 Ray E. Smoot

Licensed Embalmer No. 2560

P. O. Address 2315 [illegible]

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH
   (a) County Jackson Registration District No.
   (b) Township Kaw Primary Registration District No. Registered No. 3944
   (c) City K. C. Mo (d) Street No. General Hospital 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 Robert K. Adams
   (a) Residence, No. St.
   (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

OCCUPATION
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.
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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 1, 1939

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Rt Frontal Brain Tumor (malignant)	
53	

Other contributory causes of importance:
Bilateral Confluent Broncho Pneumonia

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

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) P. F. De Maria, M. D.
(Address) .....

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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