

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1596

FILED FEB 15 1940

Registration District No. 4027

Primary Registration District No. 4027

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Adrian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether

In this community 67 years
years, months or days)

3. (a) PRINT FULL NAME Clarice J. Adams

3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife J. H. Adams 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased Mar. 30-1863
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business 1

MOTHER FATHER { 12. Name Joseph Leape

13. Birthplace Jerseysville Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Davis

15. Birthplace Nashville Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature E. E. Robinson

(b) Address 2901 East 13th St. KC Mo

17. (a) Burial (b) Date thereof Jan 4-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Altona Legn-

18. (a) Signature of funeral director Heath & Clark

(b) Address Adrian Mo.

19. (a) — (b) —
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates

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

(d) Street No. —
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2
year 1940 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from Dec. 12
1939, to Dec. 21, 1939

that I last saw her alive on Dec. 21, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Occlusion

Due to Coronary

sclerosis

Due to —

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy —

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature E. E. Robinson (M. D. or other)

Address Adrian, Mo. Date signed Jan 4-40

RECEIVED

District Health Officer No. 7,

District File Number 2-40-263

Date Filed 2-14-40

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

and Fred J. Leath, Mo. Lic # 3343

Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3650

P. O. Address Adrian Mo

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

1396
Do not use this space.

1. PLACE OF DEATH

(a) County Bates Registration District No. 47
(b) Township Adrain Primary Registration District No. 4027 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Div (write the word)

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

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

7. AGE YEARS 76 MONTHS 9 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

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)

13. NAME

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

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 Jan 6 1940 Ethel C. Stephens Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2, 1940

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

Other contributory causes of importance:

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) E. E. Robinson, M. D.

(Address) Adrain Mo.

