

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. 11439

REG. DIST. NO. 431

Primary Registration District No. 3023

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Johnson
 (b) City or town Warrensburg
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Warrensburg-Clinic
(If not in hospital or institution, write street number or location) 1
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 61 yrs
years, months or days 2-1-72

3. (a) PRINT FULL NAME James Arthur Adams

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

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Rola Pearl Adams 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Dec-14-1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 2 Days 27
 If less than one day _____ hr. _____ min.

9. Birthplace Johnson Co. Mo. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____
 MOTHER FATHER { 12. Name Henderson Adams
 13. Birthplace Johnson Co. Mo. (1)
(City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Ryan
 15. Birthplace Johnson Co. Mo. (1)
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jim Adams
 (b) Address Warrensburg, Mo.

17. (a) Burial (b) Date thereof Mar 15-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Sweeney-Phillips
 (b) Address Warrensburg, Mo.

19. (a) Mar 14-1940 (b) Earla Lentz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
 (c) City or town Warrensburg (Rural)
(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 Mar day 11
 year 1940 hour 10 minute _____ P. M.

21. I hereby certify that I attended the deceased from Mar 6, 1940, to Mar 11, 1940
 that I last saw him alive on Mar 11, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cholecystectomy Duration _____

Due to Gall Stones

Due to 176

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

Major findings: Of operations Cholecystectomy
Gallstones
 Of autopsy none 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? 301

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

23. Signature Jim R. Talbot (M. D. or other) _____
 Address Warrensburg Date signed 3-12-40

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-4-40

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.....

Carl Priest....., Registered Apprentice No.....
working under my personal supervision.

Signed *Carl Priest*.....

Licensed Embalmer No. *3828*.....

P. O. Address *Warrensburg 2*.....

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.