

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.

U. S. 1 X1931
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

12003

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County Pettis
 (b) City or town 1
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 2

- (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 17 years
 (Specify whether years, months or days)

8. (a) PRINT FULL NAME

SUE Bell Adams

8. (b) If veteran,

name war -

3. (c) Social Security

No. -

4. Sex

Female5. Color or race W6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife

Merle Adams

6. (c) Age of husband or wife if

alive 68 years

7. Birth date of deceased

Nov-2-1868
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

71323

hr.

min.

9. Birthplace

Pettis Co
(City, town, or county)Mo
(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

James Melvin Coats

13. Birthplace

Mo
(City, town, or county)Mo
(State or foreign country)

14. Maiden name

Eugene
(City, town, or county)Mo
(State or foreign country)

15. Birthplace

Eugene
(City, town, or county)Mo
(State or foreign country)

16. (a) Informant's own signature

Mrs. Lillian Coats

(b) Address

Wasson Ave

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

2-27-40
(Month) (Day) (Year)

(c) Place: burial or cremation

Knob Knob

18. (a) Signature of funeral director

B. J. Parker

(b) Address

1212 N. 1st

19. (a)

Feb 25
(Date received local registrar)

(b)

J. T. Evans
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Mo

(b) County

Pettis

(c) City or town

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

Feb

day

25

year

1940

hour

2

minute

A. M.

21. I hereby certify that I attended the deceased from

Sept 11940to Feb 251940that I last saw him alive on Feb 24
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of Transverse Colon

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations ✓Of autopsy ✓

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

W. E. Harker

(M. D. or other)

Address

La Monte MoDate signed 2-26-40

(Licensed Embalmer's Statement on Reverse Side)

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..... *R. J. Varney*

Licensed Embalmer No. *1594*

P. O. Address..... *La Monte, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12003

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 672

Primary Registration District No. 3895

Registrar's No. 672

1. PLACE OF DEATH

(a) County Pettis
(b) City or town Brenden, Mo.
(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 _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME

Sue Bell 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 W

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

71

3

23

h. min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 28

(Date received local registrar)

(b) J. T. Evans

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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 Feb day 25
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
19 _____ to _____ 19 _____

that I last saw him alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of
transverse colon

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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? _____

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature W. E. Walser

(M.D. or other)

Address Lamonia, Mo. signed _____

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

SUPPLEMENTARY

1940
S-12003