DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15289

MAY 15 [illegible] 449
Registration District No. 449

Primary Registration District No. 5618

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede Osage 2WS
(b) ~~City or town~~
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Laclede
(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.

3. (a) PRINT FULL NAME Robert Dale Adams
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 8 (Day) 1940 (Year)

8. AGE: Years | Months | Days 18 | If less than one day hr. min.

9. Birthplace Cross Roads (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER
12. Name Vinnie Adams
13. Birthplace Laclede Co Mo (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Linda Marie Lewis
15. Birthplace Laclede Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature V. Adams
(b) Address Brownfield Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/40 (Month) (Day) (Year)
(c) Place: burial or cremation Cross Roads
18. (a) Signature of funeral director none
(b) Address 404
19. (a) 4-5-1940 (Date received local registrar) (b) J A McCormick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1940 hour 6 minute a M.
21. I hereby certify that I attended the deceased from 3-8-40, 19, to 3-26, 1940;
that I last saw him alive on 3, 1940,
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute intestinal intoxication	
Due to:	
Due to:	
Other conditions: Mongolism (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Paul A. Jenkins M.D. (M. D. or other)
Address Lebanon Mo, Date signed 4/4/40

(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
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RECEIVED
District Health Officer No. 7,
District File Number 5-40-925
Date Filed 5-8-40

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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.