DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24595

AUG 10 1940

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 712

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

1. PLACE OF DEATH

(a) County Buchanan

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

(c) Name of hospital or institution Mo Methodist Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)

In this community 4 years 2 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town St Joseph Mo (If outside city or town limits write "RURAL")

(d) Street No. 215 E Cherry (If rural, give location)

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

3. (a) PRINT FULL NAME Rosa E (ELMINA) Erickson Adkins

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife Thos. Corbin Adkins

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased 1 (Month) 30 (Day) 1884 (Year)

8. AGE: Years	Months	Days	If less than one day
55	5	2	____ hr. ____ min.

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

10. Usual occupation Housework

11. Industry or business —

MOTHER FATHER

12. Name Henry Barker

13. Birthplace — Iowa (City, town, or county) (State or foreign country)

14. Maiden name Mattie Bowman

15. Birthplace Andrew Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Thomas Corbin Adkins

(b) Address 215 E Cherry St St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-40 (Month) (Day) (Year)

(c) Place: burial or cremation Mount City Mo

18. (a) Signature of funeral director R. B. Taggart

(b) Address Mount City Mo

19. (a) 7/31/40 (Date received local registrar) (b) H. D. Featherstun (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2 year 1940 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 1, 1940, to July 2, 1940; that I last saw her alive on July 2, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Congestive heart failure	2 mos
Hypostatic pneumonia	4 days
Due to: Chronic Myocarditis	
Due to: Myocardial hypertrophy	5 yrs.
Chronic valvular heart	
Other conditions: disease. (Include pregnancy within 3 months of death)	

Major findings: Of operations — GJW

Of autopsy No

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 H. D. Sourad (M. D. or other)

Address St Joseph Mo Date signed 7-3-40

(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. G. Taggart

Licensed Embalmer No. 25-63

P. O. Address Kingsley Ne

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.