

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. 91

1. PLACE OF DEATH

(a) County Linn
(b) City or town Brookfield Mo
(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 JERRY EDWARD 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 _____

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

7. Birth date of deceased March 2 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>7</u>	<u>29</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Charles Adams

13. Birthplace Brookfield Mo
(City, town, or county) (State or foreign country)

14. Maiden name Kladya Stubbeltjean

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

16. (a) Informant's own signature Kladya Adams

(b) Address Brookfield Mo

17. (a) Burial (b) Date thereof Nov 2-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director Bill Funeral Chapel

(b) Address Brookfield Mo

19. (a) Nov 2-40 (b) Gnotthorp
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 410 Beverly
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 1
year 1940 hour 1 minute 05 P M.

21. I hereby certify that I attended the deceased from Oct 25, 1940, to Nov 1, 1940
that I last saw him alive on Nov 1, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 1 week

Due to Cerebral apnea 2 WAO

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? 4115 (Specify type of place) (e) Means of injury _____

23. Signature James Evans (M. D. or other) _____

Address Brookfield Mo Date signed 11-1-40

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY.

1072

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 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. 39120
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 496

Primary Registration District No. 3025-

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Jerry Edward 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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
7 29 hr min.

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

10. Usual occupation _____

11. Industry or business _____

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. (Month) (Day) (Year)

(Burial, cremation, or removal) _____ (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month 11 day 1 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Acrodynia
Due to Acrodynia 107W
Due to No complications as measles, or whooping cough
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? _____

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

23. Signature J. Lane Evans (M. D. or other) M.D.
Address Brookfield Mo Date signed 1-29-41

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

SUPPLEMENTARY

S-39120 1940