FEB 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1809

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 39

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

1. PLACE OF DEATH:

(a) County: Buchanan

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

(c) Name of hospital or institution: Saint Joseph Hospital (If not in hospital or institution, write street number or location)

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

In this community Since 1929

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town Saint Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 5907 Lake Ave. (If rural, give location)

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

3. (a) PRINT FULL NAME: LeRoy Adams

3. (b) If veteran, name war: —

3. (c) Social Security No. 500-07-4640

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Mrs. Frances Fern Adams

6. (c) Age of husband or wife if alive: 49 years

7. Birth date of deceased: November (Month) 6, (Day) 1891 (Year)

8. AGE: Years	Months	Days	If less than one day
49	2	4	hr. ____ min.

9. Birthplace: LaRue County, (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation: Engineer for Amisita

11. Industry or business: Asphalt Co., Kansas City, Mo.

FATHER
12. Name: Milton I. Adams
13. Birthplace: Hart County, (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Ida Rose Gumpton
15. Birthplace: Hart County (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant: Irving W. Adams

(b) Address: 1105 Henry Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13 1941 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park Cemetery

18. (a) Signature of funeral director: M. E. Siebenhaler & Sons

(b) Address: 602 South 10th Street

19. (a) Jan 13 1941 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1941 hour 11 minute 35 A.M.

21. I hereby certify that I attended the deceased from December 29, 1940 to Jan 10, 1941 that I last saw h in alive on January 10 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	
on right side	
Due to Cardiac Hyperpiotthy	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Irving W Adams (M. D. or other) MD

Address St Joseph Mo Date signed 1-11-41

(Licensed Embalmer's Statement on Reverse Side)

95C

Pneumonia on Right side

Cardiac Insufficiency

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

Mollie E. Sidenfaden, Registered Apprentice No. 145

working under my personal supervision.

Signed R. V. West

Licensed Embalmer No. 3876

P. O. Address St. Joseph 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.

No. 2B
2-21-40
X22659

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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:

(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 ..... (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.

3. (a) PRINT FULL NAME LeRoy 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 M

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
49	2	4	..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

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

MOTHER

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

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

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) 4-3-1941 (Date received local registrar) (b) R. W. Nesthead (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month June day 10

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.

	Duration
Immediate cause of death Pneumonia	
Due to Cardiac Hypertrophy	
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.

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(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 Owen W Evans (M. D. or other) M.D.

Address [illegible] Date signed 4/2-41

SUPPLEMENTARY