S. No. 2
M—1-4-41
ev. 5-1-...
I X26390

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

MAY 13 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15270

Registration District No. 1133 Primary Registration District No. 4587 Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Canalou
(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 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid 72

(c) City or town Canalou, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Grant Adams

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Lizzie Garner

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased October (Month) 30 (Day) 1867 (Year)

8. AGE:

Years	Months	Days	If less than one day
73	5	25	..... hr. ..... min.

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

10. Usual occupation Merchant

11. Industry or business Merchant

FATHER
12. Name Freeman Adams
13. Birthplace Perry Co. Ky. (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name Bethsheba Lamb
15. Birthplace Perry Co. Ky. (City, town, or county) / (State or foreign country)

16. (a) Informant Maude Adams
(b) Address Canalou, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4- 27-41 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston, Mo.

18. (a) Signature of funeral director H J Welsh
(b) Address Sikeston, Mo.

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25
year 1941 hour 2 minute 40 A: M.

21. I hereby certify that I attended the deceased from 4-25, 1941, to 4-25, 1941;
that I last saw him alive on 4-25, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	1 day
Due to	
Due to Hypertension	
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)
5 40 While at work? (e) Means of injury .....

23. Signature J. M. Sarno (M. D. or other) M. D.
Address Morehouse, Mo. Date signed 4-27-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2,
District File Number 541-571
Date Filed 5/8/41

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 Melvin L Kempe

Licensed Embalmer No. 4052

P. O. Address Sikeston, Missouri

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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15-270

Registration District No. 1133 Primary Registration District No. 4587 Registrar's No. 9

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Canalou
(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 years, months or days) In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Grant 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 Div
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 73 Months 5 Days 25 If less than one day 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)
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) 6-21-41 (Date received local registrar) (b) Jacob Koehl (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 25 year 1941 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	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature S. M. Sarno (M. D. or other)
Address Morehouse Mo Date signed

SUPPLEMENTARY

HOWENA MOORE

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

S-15270