

Registration District No. **791**

Primary Registration District No. **1003**

State File No. ....

Registrar's No. **4238**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town **St Louis, Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **BARNES HOSPITAL**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **4 days** (Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Cherokee**  
(c) City or town **Baxter Springs** **N.R. 14**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **421 E. 10th.** (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? **2** years.

3. (a) PRINT FULL NAME **EMMA JANE ADKINS**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **Unknown**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**  
6. (b) Name of husband or wife **Single** 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased **May 19 1919**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**22 0 0** hr. min.

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

10. Usual occupation **Unemployed**

11. Industry or business.....

MOTHER FATHER { 12. Name **Jess Adkins**  
13. Birthplace **Granby Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Meda Turner**  
15. Birthplace **Barry Co. Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Jess Adkins**  
(b) Address **Baxter Springs, Kan.**

17. (a) **Removal** (b) Date thereof **5/20/41**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Baxter Springs, Kan.**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Ave.**

19. (a) **MAY 20 1941** (b) **J. Buebeck**  
(Date of issue) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **19**  
year **1941** hour **12** minute **30** P.M.

21. I hereby certify that I attended the deceased from **MAY 15**, 19**41**, to **MAY 19**, 19**41**;  
that I last saw h.e.r. alive on **MAY 19**, 19**41**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Tuberculous meningitis** Duration **3 weeks**  
Due to **miliary tuberculosis** ? **3-4 week**  
Due to **involving lungs**  
Other conditions **13/15**  
Major findings: Of operations **not notable** **23** PHYSICIAN  
Of autopsy **confirmation of above** 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 **Gordon F. Moore** (M. D. **Moore**)  
Address **BARNES HOSPITAL** Date signed.....

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

5000  
17  
9

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, fact should be so stated above.