

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31158**

FILED OCT 14 1941

Registration District No. **87**

Primary Registration District No. **3007**

Registrar's No. **377**

1. PLACE OF DEATH

(a) County **Butler**  
 (b) City or town **Poplar Bluff, Mo.**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution **Poplar Bluff Hospital**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **about 3 days**  
 (Specify whether  
 In this community \_\_\_\_\_  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Butler**  
 (c) City or town **Poplar Bluff, MALEDEN**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **W. Olive**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Pathe Joe Adams**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **Aug. 19 1941**  
 (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months **1** Days **13** If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **James Harold Adams**

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

14. Maiden name **Josephine Medlin**

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

16. (a) Informant **Rose Medlin**  
 (b) Address **Malden Mo.**

17. (a) **Burial** (b) Date thereof **9-27-41**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Malden Mo.**

18. (a) Signature of general director **Walter Feneale**  
 (b) Address **Dexter Mo.**

19. (a) **10-3-41** (b) **Belle Kinne**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **27**  
 year **1941** hour **4** minute **20 a.** M.

21. I hereby certify that I attended the deceased from **Sept 25** 19**41**, to **Sept 27** 19**41**; that I last saw her alive on **Sept 27** 19**41**; and that death occurred on the date and hour stated above.

Immediate cause of death **infectious mononucleosis**  
 Due to **diarrhoea**

Duration **7 days**  
**7 days**

Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) **1190**

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? \_\_\_\_\_ (Specify type of place) (a) Mechanism of injury \_\_\_\_\_

23. Signature **O. J. Kinne** (M. D. or other)  
 Address **Poplar Bluff Mo.** Date signed **9/27/41**

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

RECEIVED

District Health Office No. 2

District File Number 104-1-14-24

Date Filed 12/8/41

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**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.**

2B  
1-41  
29288

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 311588  
Registrar's No. 377

Registration District No. 89

Primary Registration District No. 3007

1. PLACE OF DEATH  
(a) County Butler  
(b) City or town Doplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution P.B. Hospital  
(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 Pattie J. Adams  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 19 - 1944  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_  
(City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 10-23-41 Belle Stinne  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 2  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
to \_\_\_\_\_, 19\_\_\_\_;  
that I have seen him/her \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
(Immediate cause of death) marasmus  
Duration \_\_\_\_\_

Due to diarrhea  
Enterocolitis  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
1190

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

1941

5-31158