

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED NOV 19 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

34881

State File No.

Registrar's No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Gentry
 (b) City or town Albany Rural Albany Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Rural 6 mile East of Albany
 (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

OLLIE E. 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 W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive _____

years

7. Birth date of deceased

Nov

(Month)

14

(Day)

1864

(Year)

8. AGE:

Years

Months

Days

If less than one day

778

hr.

min.

9. Birthplace

Gentry County

(City, town, or county)

MO

(State or foreign country)

10. Usual occupation

House Wife

11. Industry or business

MOTHER FATHER

12. Name

William Chipp

13. Birthplace

Indiana

(City, town, or county)

(State or foreign country)

14. Maiden name

Martha Hase

15. Birthplace

Marion County

(City, town, or county)

Indiana

(State or foreign country)

16. (a) Informant's own signature

James Adams

(b) Address

Albany Mo

17. (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

Oct 24 1941

(Month) (Day) (Year)

(c) Place: burial or cremation

Foster

18. (a) Signature of funeral director

W. H. Noble

(b) Address

New Hampton Mo

19. (a)

Nov 4 1941

(Date received local registrar)

(b)

W. T. Smart

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry
 (c) City or town Albany Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6 mile East of Albany
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
 year 1941 hour 9 minute 30 P.M.

21. I hereby certify that I attended the deceased from June
 _____, 1941, to Oct 4, 1941;
 that I last saw her alive on Oct 22, 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death

Myocarditis

Duration

4 yrs

Due to

Acute Indigestion

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 sta-
 tistically

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

R. L. Green

(Mr. D. or other)

Address

New Hampton Mo

Date signed

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.....

W. H. Noble....., Registered Apprentice No.....
working under my personal supervision.

Signed W. H. Noble.....

Licensed Embalmer No. 2904.....

P. O. Address New Hampton, N.H......

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.