No. 2
1-4-41
19
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 20 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11313

Registration District No. 547 Primary Registration District No. 3029 Registrar's No. 88

4
3
4

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

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Residence 510 Winter
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 064
(c) City or town Hannibal 3
(If outside city or town limits, write "RURAL")
(d) Street No. 510 Winter 4
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes name country D

3. (a) PRINT FULL NAME Lizzie Louise Adams

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

4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife John Adams
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years About 64 | Months | Days | If less than one day hr. min.

9. Birthplace Springfield Illinois 1
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
16. (a) Informant Jesse Nichelson
(b) Address 510 Winter
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/6/42 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Olivet
18. (a) Signature of funeral director Crawford Smith
(b) Address 902 Broadway Hannibal
19. (a) 4/7/42 (Date received local registrar) (b) Robt. W. Connor (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3
year 1942 hour About 9:30 minute P. 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 Myocarditis. Arterio Scelerosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 93	
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 Crawford Smith (M. D. or other) Coroner
Address 902 Broadway Date signed 4/1/42

1144

(Licensed Embalmer's Statement on Reverse Side)

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 James G. Moles

Licensed Embalmer No. 3296

P. O. Address Hannibal Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

U. S. No. 2B
OM—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 113 12

Registration District No. 549 Primary Registration District No. 3029 Registrar's No.

1. PLACE OF DEATH:
(a) County: Marion
(b) City or town: Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Resirdence
(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: Missouri (b) County: Marion
(c) City or town: Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No.: 510 Winter
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Lizzie Louisa 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: Unknown (Month) (Day) (Year)
8. AGE: Years: About 64 Months: Days: If less than one day: hr. min.
9. Birthplace: Springfield Illinois (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business .....
MOTHER FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: Jesse Nichelson
(b) Address: 510 Winter Street
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4/4/42 (Month) (Day) (Year)
(c) Place: burial or cremation: Mount Olivet
18. (a) Signature of funeral director: Crawford Smith
(b) Address: 902 Broadway Hannibal
19. (a) ..... (Date received local registrar) (b) Robt W Connor (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April Day: 3 Year: 1942 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Found dead	
Due to: Chronic Myocarditis	
Arterio Scelerosis	
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? .....
While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature: Crawford Smith (M. D. or other) Coroner
Address: 902 Broadway Hannibal Date signed .....

SUPPLEMENTARY

11313