

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 12 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15702

State File No. \_\_\_\_\_

Registrar's No. 7

Registration District No. 792-798

Primary Registration District No. 6041

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Rural South mo  
(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 all her life years, months or days)

3. (a) PRINT FULL NAME Lillie C Adams

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced divorced  
6. (b) Name of husband or wife James P Adams 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 27 1844 (Month) (Day) (Year)

8. AGE: Years 97 Months 1 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Henry Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation None

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

MOTHER FATHER { 12. Name Samuel Shannon  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Martha Adams  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mother Adams  
(b) Address Maple St. R. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1942 (Month) (Day) (Year)  
(c) Place: burial or cremation Smith Chapel

18. (a) Signature of funeral director Campbell  
(b) Address Maple St. R. #2

19. (a) May 8th 1942 (Date received local registrar) (b) Mrs. W. E. Shackelford (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Saline Fork (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 Jan day 1 year 1942 hour 12 minute 30 AM M.

21. I hereby certify that I attended the deceased from Dec 27 to Dec 31 1941  
that I last saw her alive on Dec 29 1941  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Alters Sclerosis Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 97

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(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 Shackelford (M. D. or other) \_\_\_\_\_

Date signed 4/1/42

1255 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 5-11-42

---

---

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, ~~on~~ by \_\_\_\_\_,  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_,  
working under my personal supervision.

Signed \_\_\_\_\_

*Joe H. Renier*

Licensed Embalmer No. 1171

P. O. Address Marshall Mo

**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.**