

FILED JUL 13 1942

Registration District No. _____

Primary Registration District No. 201

Registrar's No. 1421

1. PLACE OF DEATH: *St Louis*
 (a) County *St Louis*
 (b) City or town *Koch*
 (c) Name of hospital or institution: *Robert Koch Hospital*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *1 yr 3 mo 1 day*
 (Specify whether *20 years*)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME *CLIFFIE ALENE ADAMS*
 3. (b) If veteran, name war _____
 3. (c) Social Security No. *xxx*

4. Sex *F* / 5. Color or race *N*
 6. (a) Single, widowed, married, divorced *Widow*
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: *Jan 8 1922*
 (Month) (Day) (Year)

8. AGE: Years *20* Months *5* Days *21*
 If less than one day _____ hr. _____ min.

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

10. Usual occupation *nil*

11. Industry or business _____

MOTHER FATHER
 12. Name *Albert Adams*
 13. Birthplace *Washington Mo*
 (City, town, or county) (State or foreign country)
 14. Maiden name *Ruth Riddle*
 15. Birthplace *Washington Mo*
 (City, town, or county) (State or foreign country)

16. (a) Informant *Hospital record*
 (b) Address *Robert Koch Hosp*

17. (a) *Burial* (b) Date thereof *7/3/1942*
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Washington Park Cem*

18. (a) Signature of funeral director *Chas. J. Gates*
 (b) Address *4107 Finney Ave.*

19. (a) *JUL 2 - 1942* (b) *R. M. Clouston*
 (Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State *Missouri* (b) County *St Louis*
 (c) City or town *St Louis*
 (If outside city or town limits, write "RURAL")
 (d) Street No. *1185 Hamilton*
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *29*
 year *1942* hour *6* minute *05* P. M.

21. I hereby certify that I attended the deceased from *March 28 1941* to *June 29 1942*
 that I last saw him alive on *June 29 1942*
 and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Tuberculosis
Intestinal Tuberculosis
 Duration *1 1/2 yrs +*

Due to _____

Due to _____

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

Major findings:
 Of operations _____
 Of autopsy *Pulm + Int. Tuberculosis*
 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 *Frank Cohen* (M.D. or other) _____
 Address *Robert Koch Hosp* Date signed *6/30/42*

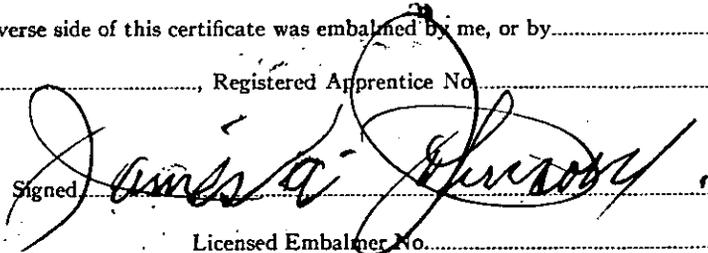
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 with the above constitutes grounds for revocation of license.)

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