No. 12
9-4-41
17-39
X2948

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 10 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

10205

State File No.

Registration District No. 127 | Primary Registration District No. 3464 | Registrar's No. 3

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

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Willard (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Murray Township, / (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether In this community) Several years (years, months or days)

2. USUAL RESIDENCE OF DECEASED: 39
(a) State Missouri (b) County Greene 0
(c) City or town Willard, Missouri. 0 (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country 0

3. (a) PRINT FULL NAME Daniel Clarkston Adams,
3. (b) If veteran, name war Nil
3. (c) Social Security No. Nil

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Lillie F. Burkholder
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased June, 17th., 1862 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
80	9	1	hr. min.

9. Birthplace Christian County Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Retired Merchant
11. Industry or business Furniture

MOTHER FATHER
12. Name Wiley Adams
13. Birthplace (City, town, or county) Missouri (State or foreign country)
14. Maiden name Jane Mallard,
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Lillie F. Adams
(b) Address Willard, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-43 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetry, Springfield, Mo
18. (a) Signature of funeral director
(b) Address Walnut Grove, Missouri
19. (a) 3-19-43 (Date received local registrar) (b) Jane Appleby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 18 day year 1943 hour 3 minute 15 A. M.
21. I hereby certify that I attended the deceased from Feb. 25th, '43 to March 18th, 1943; that I last saw him alive on March 16th, 1943, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Uremic Poisoning and associated infection	
Due to Prostatic enlargement with urinary incontance	
Due to Patient has had a mycardifis for a good many years and above	
Other conditions (Include pregnancy within 3 months of death) condition no doubt became too great for the damaged heart.	

Major findings: Of operations Suprapubic operation under local anaesthetic performed on Feb. 25, 1943.

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 2

23. Signature Dr. [illegible] (M. D. or other) D. O.
Address Willard, Missouri Date signed 3/[illegible]/43

1242 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office,
County File Number 43-4-~~420~~ 27
Date Filed 4/8/43

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 Irene A. Brim

Licensed Embalmer No. 2664

P. O. Address Walnut Grove, Missou

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

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

S. No. 2B
4—8-21-41
P 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. 10203

Registration District No. 127 Primary Registration District No. 5464 Registrar's No.

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Willard

(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 years, months or days) In this community

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

3. (a) PRINT FULL NAME Daniel C Adams.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 17 (Month) (Day) 1863 (Year)

8. AGE: Years 80 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Name, burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1943 hour minute 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.

Immediate cause of death ..... Duration

Due to

Due to

Other conditions (Including pregnancy within 3 months of death)

Autopsy findings:

Operation: Date of operation

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 (M.D. or other)

Address Date signed

SUPPLEMENTARY

SUPRAPUBIC OPERATION PERFORMED BECAUSE THE PATIENT COULD NOT URINATE AND IMPOSSIBLE TO LONGER PASS A CATHETER. CONDITION OF PROSTATIC ORIGEN (PROSTATIC ENLARGEMENT) NO BIOPSY PERFORMED AND IF MALIGNANCY WAS PRESENT IT WOULD HAVE BEEN OF THE PROSTATE. AS SO. NO AUTOPSY WAS PERFORMED.

DR. R. W. REID
WILLARD, MISSOURI 137a