V. S. No. 2
50M—5-42
Rev. 5-17-39
P 1 X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 19157

Registration District No. 3211 — Primary Registration District No. 4470 — Registrar's No. 6

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Arrow Rock
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether years, months or days)
In this community all of life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline
(c) City or town Arrow Rock
(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

3. (a) PRINT FULL NAME John Henry Adams
3. (b) If veteran, name war no
3. (c) Social Security No.
4. Sex male
5. Color or race negro
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Phoebe Adams
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased Dec. (Month) 18th (Day) 1878 (Year)

8. AGE: Years 64 | Months 3 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Saline Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation laborer
11. Industry or business
FATHER
12. Name John H. Adams
13. Birthplace Ky. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Matilda Crosby
15. Birthplace Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Mrs. John Adams
(b) Address Arrow Rock, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 4/7/'43 (Month) (Day) (Year)
(c) Place: burial or cremation Sappington Cemetery
18. (a) Signature of funeral director Hill Brothers,
(b) Address Slater, Mo.
19. (a) Apr. 7-1943 (Date received local registrar) (b) Mrs. W. E. Shackelford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 4th year 1943 hour 7 minute a M.
21. I hereby certify that I attended the deceased from Mar 28, 1943 to April 4, 1943 that I last saw h. alive on April 3, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Fracture of skull	
Due to a fall on walk	
Due to	
Other conditions (Include pregnancy within 3 months of death) senility	
Major findings: Of operations none	
Of autopsy none	

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) accident
(b) Date of occurrence March 28 1943
(c) Where did injury occur? Arrow Rock (City or town) Saline Co. (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home (Specify type of place) on Concrete
While at work? no (e) Means of injury walk
23. Signature M. S. McGuire (M. D. or other) MD
Address Boonville, Mo. Date signed 4-5-43

(Licensed Embalmer's Statement on Reverse Side)

3-13-43

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 A. O. Hill

Licensed Embalmer No. 3090

P. O. Address Slater-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.