

3-1
M-2-43
5-17-39
-1 X35597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31179**
Registrar's No. **925**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Mercy Hospital**
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution **1 day** (Specify whether
In this community **Life** years, months or days) (Specify whether

3. (a) PRINT FULL NAME **Betty Louise Adams**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **November 11, 1941**
(Month) (Day) (Year)

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

9. Birthplace **St Joseph Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business

MOTHER FATHER { 12. Name **Claude Adams**
13. Birthplace **St Joseph Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Maile Cott**
15. Birthplace **St Joseph Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Claude Adams**

(b) Address **2726 Lafayette St**

17. (a) **Burial** (b) Date thereof **8-21-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St Anselm Church**

18. (a) Signature of funeral director **Fleeman & Son Inc.**

(b) Address **St Joseph Mo.**

19. (a) **8/25/43** (b) **Rose Herzog**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **2726 Lafayette St**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19th**
year **1943** hour **8** minute **A** M.

21. I hereby certify that I attended the deceased from **Aug 15th 1943** to **Aug 19 1943**
that I last saw her alive on **Aug 19th 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia** Duration

Due to **Infection of right arm**

Due to

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

Major findings:
Of operations **24 a**
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 **Dr. John Hartsock** (M. D. or other) **D.O.**

Address **222-24 Logan Bldg** Date signed **Aug 19**

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

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

Robert H. Yaph

Licensed Embalmer No.

3308

P. O. Address

St. Joseph, 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.