

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED DEC 11 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38120**
 Registrar's No. **169**

Registration District No. **424**

Primary Registration District No. **5575 5590**

1. PLACE OF DEATH:

(a) County **Jefferson**
 (b) City or town **Rural**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Route #1 Grubville, Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **78 yrs.**
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Mary Anne Adams

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** / 5. Color **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **James F. Adams**

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

7. Birth date of deceased **October 10 - 1865**

8. AGE:

Years **78** Months **0** Days **18** If less than one day hr. _____ min. _____

9. Birthplace

Washington Co. Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation

Widowed Housewife

11. Industry or business

MOTHER FATHER

12. Name **Frank Liverar**

13. Birthplace **Unknown**

14. Maiden name **Elvira Boyer**

15. Birthplace **Washington Co. Missouri**
 (City, town, or county) (State or foreign country)

16. (a) Informant

Robert Adams

(b) Address

R-1 - Grubville, Mo

17. (a)

Burial
 (Burial, cremation, or removal)

(b) Date thereof **11-9-43**
 (Month) (Day) (Year)

(c) Place: burial or cremation

Ware - Mo.

18. (a) Signature of funeral director

J. H. Mathews

(b) Address

Wesley - Mo

19. (a)

Dec 3-43
 (Date received local registrar)

(b)

A. H. Eaton
 (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jefferson**
 (c) City or town **Grubville**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Rt. 1**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **8**
 year **1943** hour **11** minute **55 PM.**

21. I hereby certify that I attended the deceased from **Oct. 2** 19**43** to **Nov. 8** 19**43**
 that I last saw him alive on **Oct. 3/1943** 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of the liver with metastasis.**

Due to _____

Due to _____

Other conditions **myocarditis**
 (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

Duration

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)
 (Specify type of injury)

23. Signature **Walter E. Smith** (M. D. or other)
 Address **Des Moines, Mo** Date signed **11/10/43**

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.....

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.