

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FILED JAN 14 1944

43962

Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 336
(b) Township County Primary Registration District No. 612X
(c) City Arroll, Mo. (d) Street No. _____ St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Preston Beck Adkins St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. STATE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF Callie Adkins
(or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1-1875

7. AGE YEARS 68 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

13. NAME Preston Adkins

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

15. MOTHER'S NAME Arch Higginbotham

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

17. INFORMANT (NAME) (ADDRESS) W. Adkins Arroll, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Rest DATE Dec. 23-1943

19. FUNERAL DIRECTOR (NAME) (ADDRESS) None

20. FILED 1-3- 19 43 Frank Hyndman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-22-1943

22. I HEREBY CERTIFY, That I attended deceased from 5-12- 19 43, to 12-22- 19 43

I last saw him alive on 12-15- 19 43 Death is said

to have occurred on the date stated above, at 1:00 P. M.

The principal cause of death and related causes of importance were as follows:

Chronic Empyema
following pneumonia Date of onset 10-1-43

Other contributory causes of importance: Chronic Myocarditis 1941

Name of operation None Date of None

What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. Adkins, M. D.

(Address) Willow Springs, Mo.

RECEIVED

District Health Officer No. 5,

14463
1. 12-44

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.

Not Embalmed

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, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*

Registrar's No. _____

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH

- (a) County *Shannon*
(b) City or town *Rural*
(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 _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

Preston B. Adkins

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 *w*

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

Jan.
(Month)

(Day)

(Year)

8. AGE:

Years *68*

Months

Days

If less than one day _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar)

(b) _____

(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec.* year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to *Chronic Empyema following pneumonia* *2 yrs.*
bronchial pneumonia

Due to *Chronic Myocarditis* *1 year*

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

Major findings: Of operations _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature *W.D. Callahan* (M. D. or other) _____
Address *Willow Springs, Mo* Date signed *1-15-44*

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

SUPPLEMENTARY

5-43960