

43971

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 13 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 116

Registration District No. 337

Primary Registration District No. 4499

1. PLACE OF DEATH

(a) County Shelby
(b) City or town Shelbina mo
(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 50 years (years, months or days)

3. (a) miss PRINT FULL NAME Minnie C. Adams

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased April 5 1865
(Month) (Day) (Year)

8. AGE: Years 78 Months 8 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Monroe Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Preston Adams

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

14. Maiden name Catharine Conner

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

16. (a) Informant Bessie Adams

(b) Address Shelbina mo

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof Dec 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Shelbina

18. (a) Signature of funeral director Stacy

(b) Address Shelbina

19. (a) Jan 5 44 (Date received local registrar) (b) Marge Gooch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County Shelby
(c) City or town Shelbina
(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 day 14
year 1943 hour 9 minute _____ P. M.

21. I hereby certify that I attended the deceased from 3-4-43
to 12-14-43, 19____, to _____, 19____;
that I last saw her alive on 12-14-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 hrs
Asterio-Schiasis
Staphylococci 20 yrs
Pericarditis 10 yrs

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

Major findings:
Of operations _____
Of autopsy 61

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 A. M. Wood (M. D. or other) _____
Address Shelbina mo Date signed 12-24-43

RECEIVED

District Health Officer No. 10

District File Number 44-172

Date Filed JAN 12 1944

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. 1437

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County *Shelby*
(b) City or town *Shelbyville*
(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 *50 yr.* years, months or days)

3. (a) PRINT
FULL NAME

Minnie C. Adams

3. (b) If veteran,
name war _____

3. (c) Social Security
No. _____

4. Sex *7* 5. Color or *W* race
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 *April 5*
(Month) (Day) (Year)

8. AGE: Years *78* Months *8* Days *8* (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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Jan. 5 1944* (b) *Madge Good*
(Date received local registrar) (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* *1943* Year *1943* Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 _____

Due to _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

5-43671