

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 10 1944

Registration District No. 1097

Primary Registration District No. 4097

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: L
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 60 years
years, months or days)

3. (a) PRINT FULL NAME Robert W Adams

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nellie B Adams 6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased Dec 10 1876
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 22 If less than one day hr. _____ min. _____

9. Birthplace Pleasant Hill Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Banker

11. Industry or business President

12. Name Quinton Adams
13. Birthplace New York
(City, town, or county) (State or foreign country)
14. Maiden name Adams
15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Nellie B Adams

(b) Address Harrisonville

17. (a) Cremation (b) Date thereof 27 of May 44
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO.

19. (a) Feb. 3, 1944 (b) Margaret Valle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Harrisonville Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 604 East Walnut
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2
year 1944 hour 7 minute 0 M.

21. I hereby certify that I attended the deceased from Feb 2
1944 to Feb 2 1944
that I last saw him alive on Feb 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thromboses
Sudden death

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 J. W. Scott (M. D. or other) 0

Address Harrisonville Mo Date signed Feb 3

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

Ernest Rumberger

Registered Apprentice No.

~~working under my personal supervision.~~

Signed

Ernest Rumberger

Licensed Embalmer No.

366 & 8

P. O. Address

Hammonville, Va

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.