No. 2
1-4-41
-17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 13 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 19404

Registration District No. 374 Primary Registration District No. 6276 Registrar's No.

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Rural Union Twp
(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 Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth
(c) City or town Rural 112
(If outside city or town limits, write "RURAL")
(d) Street No. Grant City, Mo.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Margret Adams
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F. 1
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wm Adams
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased Sept. (Month) 21 (Day) 1861 (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	5	27	hr. min.

9. Birthplace Vinton (City, town, or county) Ohio (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name John Ewing
13. Birthplace Vinton (City, town, or county) Ohio (State or foreign country)
MOTHER
14. Maiden name Mary McFeish
15. Birthplace Glascow (City, town, or county) Scotland (State or foreign country)
16. (a) Informant Wm Adams
(b) Address Grant City, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-44 (Month) (Day) (Year)
(c) Place: burial or cremation Kirk Cemetery
18. (a) Signature of funeral director A. C. Dunfee
(b) Address Grant City, Mo.
19. (a) April 5-1944 (Date received local registrar) (b) Arlene Scadden (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18
year 1944 hour 1 minute 30 A.M.
21. I hereby certify that I attended the deceased from 3-16-44
Mch 16 1944 to Mch 17 1944
that I last saw h alive on Mch 17 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia Both Lungs	3 days
Due to	
Due to	
Other conditions Sanitary (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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature John Andrews (M. D. or other)
Address Grant City Mo Date signed 3/16/44

(Licensed Embalmer's Statement on Reverse Side)

JUN 27 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.....Arch C. Dunfee.....

Licensed Embalmer No.....3252.....

P. O. Address.....Grant City, Mo.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 374 Primary Registration District No. 6276 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Worth

(b) City or town Rural Union Twp (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)

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

3. (a) PRINT FULL NAME Margaret Adams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex J

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 21 (Day) 1861 (Year)

8. AGE: Years 82 Months 5 Days 27 If less than one day hr. min.

9. Birthplace (City, town, or county) Ohio (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 18 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Both lung

Due to Bronchial Both 3/4 days

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

107

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

DEPARTMENT
OF COMMERCE

1944 JUN 26 AM 9 22

CHIEF CLERK

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