

FILED OCT 9 1944
Registration District No. **274**

Primary Registration District No. **3052**

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

1. PLACE OF DEATH:

(a) County **PETTIS**
 (b) City or town **SEDALIA**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **BOTHWELL HOSPITAL**
 (If not in hospital or institution, write street number or location) **0**
 (d) Length of stay: In hospital or institution **4 DAYS** (Specify whether
 In this community **35 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **PETTIS**
 (c) City or town **SEDALIA**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **610 W. 7TH.**
 (If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **EMMA JANE ADAMS**
 (b) If veteran, name war
 (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **SEPT.** day **6TH**
 year **1944** hour **4** minute **25H.** M.
 21. I hereby certify that I attended the deceased from **1936**
 19 to **Sept 6** 1944
 that I last saw h **er** alive on **Sept 5** 1944
 and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **WIDOW**
 (b) Name of husband or wife **PHIL R.** (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased **6 - 29 - 1870**
 (Month) (Day) (Year)

Immediate cause of death **Chronic Myocarditis** Duration **4 years**
 Due to **Arterio Sclerosis** **4 years**
 Due to **Pericardial Anemia** **8 years**

8. AGE: Years Months Days If less than one day
73 **2** **7** **hr** **min.**

Other conditions **None**
 (Include pregnancy within 3 months of death)
 Major findings: **None**
 Of operations **None**
 Of autopsy **No**
 PHYSICIAN **938**
 Underline the cause to which death should be charged statistically.

9. Birthplace **ILLINOIS**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **HOUSEWIFE**

MOTHER FATHER
 11. Industry or business
 12. Name **JULIS H. VOLKER**
 13. Birthplace **GERMANY**
 (City, town, or county) (State or foreign country)
 14. Maiden name **LUCY FARROW**
 15. Birthplace **MARYLAND**
 (City, town, or county) (State or foreign country)

16. (a) Informant **HERBERT ADAMS**
 (b) Address **SEDALIA**

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) **No**
 (b) Date of occurrence
 (c) Where did injury occur? **None** (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

17. (a) **BURIAL** (b) Date thereof **9-7-1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **CROWN HILL CEM.**

18. (a) Signature of funeral director **Gillespie**
 (b) Address **SEDALIA**
 19. (a) **9/6/44** (b) **Ans Anna Berger**
 (Date received local registrar) (Registrar's signature)

While at work (Specify type of place) (c) Means of injury
 23. Signature **Jos B. Carls M.D.** (M. D. or other)
 Address **Sedalia Mo** Date signed **9-6-44**

1022

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed _____

10-6-44

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.

Signed _____

L. E. Boulestin

Licensed Embalmer No. _____

3867

P. O. Address _____

Sealatin Mo

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.