

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37161

State File No.

Registrar's No.

FILED NOV 28 1944

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
430 North 17th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community 30 yrs. 4 mos. 16 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME KATE LOGAN ADAM

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex female 5. Color or race white 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 June 30th. 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 4 16 hr. min.

9. Birthplace Saint Joseph, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation retired milliner

11. Industry or business Millinery,

12. Name James Adam
13. Birthplace Glasgow, Scotland, 4
(City, town, or county) (State or foreign country)
14. Maiden name Lydia I. Barker
15. Birthplace Dremville, Canada, 6
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Perry Fulkerson
840 No. 25th St. St. Joseph, Mo.

17. (a) burial (b) Date thereof 11/17/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora Cemetery

18. (a) Signature of funeral director

(b) Address 319 So. 10th

19. (a) 11/17/44 (b) Helen J. Pickel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 430 North 17th
(If rural, give location)
(e) Citizen of foreign country? (Yes) No
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16th
year 1944 hour 3 minute 15 A. M.

21. I hereby certify that I attended the deceased from Nov 9 1944 to Nov 15 1944
that I last saw him alive on Nov 15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
Duration 5 days

Due to

Due to

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

Major findings: Of operations

Of autopsy None

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 Frank J. Anderson (M. D. or other)
Address 620 S. 10th Date signed 11/18/44

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. F. X. Hartigan
Kirkpatrick Bldg.

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. 1710

P. O. Address St Joseph W.

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.