

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38335

State File No. ....

FILED DEC 2 1944  
Register District No. ....

Primary Registration District No. 4327

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Iberia  
(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) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Life years, months or days

3. (a) PRINT FULL NAME GRETHEL ADAMS

3. (b) If veteran, name was no 3. (c) Social Security No. no

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Loran Adams 6. (c) Age of husband or wife if alive 30 years  
7. Birth date of deceased Dec-8-1914 (Month) (Day) (Year)

8. AGE: Years 29 Months 10 Days 26 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

12. Name Ray C. Casey  
13. Birthplace Bucktree MO (City, town, or county) (State or foreign country)  
14. Maiden name Ozga Penubenton  
15. Birthplace Iberia MO (City, town, or county) (State or foreign country)

16. (a) Informant Loran Adams (b) Address Iberia MO

17. (a) Burial (b) Date thereof 11-8-44 (Month) (Day) (Year)

(c) Place: burial or cremation Iberia

18. (a) Signature of funeral director Ch Casey

(b) Address Iberia MO

19. (a) 10/15/44 (b) Jessie Perkins (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Miller  
(c) City or town Iberia (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 4 year 1944 hour 10 minute P M.

21. I hereby certify that I attended the deceased from 4/18/44 to 10/4/44 and that I last saw her alive on 10/4/44 and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

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) Suicide  
(b) Date of occurrence 10/4/44  
(c) Where did injury occur? Iberia Miller MO (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on Farm

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury Suicide

23. Signature Wm. A. Gould (M. D. or other) Do. Address Iberia MO Date signed 10/14/44

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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. ....

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. Dec

Registration District No. 215

Primary Registration District No. 4327

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Shenig  
(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)

3. (a) PRINT  
FULL NAME

Brethel 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 m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Dec  
(Month) (Day) (Year)

8. AGE:

Years 29  
Months 12  
Days 12

If less than one day  
hr. \_\_\_\_\_ min.

9. Birthplace

(City, town, or county)

(State or foreign country) MO

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)

(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)

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 Nov  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death suicide  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) suicide  
(b) Date of occurrence Nov 4 1944  
(c) Where did injury occur? Shenig Miller MO  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on farm

While at work? \_\_\_\_\_

(Specify type of place)

(e) Means of injury by Poisoning

23. Signature

Wm. A. Gould  
Shenig MO

(M. D. or other) DO

Date signed

12/14/44

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

SUPPLEMENTARY

FEB 17 1947

FEB 12 1947

38335