

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 31 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 762

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Bethesda General Hospital 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month - 8 days  
(Specify whether 0)

In this community 0  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 00

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 3651 Vista  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Michael Wayne Adams

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M 0 5. Color or race W

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

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

7. Birth date of deceased Nov. 13 1944  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

Years	Months	Days	hr.	min.
	<u>1</u>	<u>8</u>		

9. Birthplace St. Louis, Mo. U  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Michael Wayne Adams

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Anna Lee Adams

15. Birthplace Mo. U (City, town, or county) (State or foreign country)

16. (a) Informant Anna Lee Adams

(b) Address 3651 Vista Ave.

17. (a) Buried (b) Date thereof 1-25-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson

(b) Address City Health Dept

19. (a) 1-24-45 (b) J. F. Bredeek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 22  
year 1944 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov. 13, 1944, to Dec. 22, 1944, that I last saw him alive on Dec. 22, 1944, and that death occurred on the date and hour stated above.

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

Pneumonia, Bronchial  
Dehydration  
Retinitis  
? Congenital malformation

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

? Congenital malformation

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

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 107

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? \_\_\_\_\_

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

23. Signature Dr. Wm H. Riley (M.D. or other) \_\_\_\_\_  
Address 4605 Maryland Date signed 1/25/45

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

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**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.**