

8-43
5-17-39
X37823

State File No.

Registrar's No. 1

FILED FEB 13 1945

Registration District No. 15-2

Primary Registration District No. 5623A

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural - Sniabar Twms.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4 Mi. NW of Oak Grove
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 1 yr.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette **5.4**
(c) City or town Odessa, Mo. **4**
(If outside city or town limits, write "RURAL") **11**
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Daniel A. J. Adams

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 0 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

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

7. Birth date of deceased Jan. 4, 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired rural Mail Carrier

11. Industry or business _____

MOTHER FATHER { 12. Name John Quincy Adams
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Rhoebe Hall
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J.B. Alumbaugh
(b) Address Oak Grove, Mo.

17. (a) Burial (b) Date thereof Jan. 22, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
Odessa, Mo.

18. (a) Signature of funeral director E. B. Kassar
(b) Address Odessa, Mo.

19. (a) Jan. 25, 1945 (b) Mrs. Jessie M. Histon.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan. day 20
1945 year hour minute M.

21. I hereby certify that I attended the deceased from Jan 22 1945 to Jan 15 1945
that I last saw him alive on Jan 15 1945
and that death occurred on the date and hour stated above
Immediate cause of death W. M. Coma Duration _____

Due to Heart Disease
Due to Cardiac Disease

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 statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
Where did injury occur? _____ (City or town) (County) (State)
(c) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature J. C. Selady (M. D. or other) _____
Address Odessa, Mo. Date signed 1-22-45

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

18-2

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... *Irving L. Hugman*
Licensed Embalmer No. 2541
P. O. Address Odessa, 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.

Registration District No. 15 2

Primary Registration District No. 5573 A

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Rural Snodgrass
 (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 Daniel A J Adams
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Jan 4 1941
 (Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

MOTHER FATHER

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) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (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 Jan 20
 year 1941 - hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Due to Chronic Nephritis
 Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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 _____

SUPPLEMENTARY INFORMATION REQUESTED

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

3-2 5227

MAY 28 1945