S. No. 2
M—8-43
. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 21 1945

Registration District No. 5-12

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 12812

Primary Registration District No. 1000

Registrar's No. 422

**1. PLACE OF DEATH:**

(a) County Buchanan (b) City or town St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether)

In this community 5 years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Holt 44

(c) City or town Fortescue 6
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location) 3

(e) Citizen of foreign country? No 1 (Yes or No)

If yes, name country

**3. (a) PRINT FULL NAME** Iva Adkison

3. (b) If veteran, name war

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 Carl M. Adkison | 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug. (Month) 9th (Day) 1907 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 8 | 11 | hr. min. |

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

10. Usual occupation House Work

11. Industry or business

MOTHER FATHER

12. Name Jesse Kirby

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

14. Maiden name Margaret Baker

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

16. (a) Informant Carl M Adkison

(b) Address Fortescue Mo

17. (a) Burial M.D. City Mo (Burial, cremation, or removal) (b) Date thereof 4-23-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mound City Mo

18. (a) Signature of funeral director

(b) Address Mound City Mo

19. (a) 4-20-45 (Date received local registrar) (b) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month 4-20-45 day

year hour 10 minute A.M.

21. I hereby certify that I attended the deceased from 4-9-45, 19, to 4-20-45, 19; that I last saw her alive on 4-20-45, 19; and that death occurred on the date and hour stated above.

| Duration |
|---|
| Immediate cause of death Peritonitis general. |
| Due to Produced abortion |
| Due to |
| Other conditions (Include pregnancy within 3 months of death) |
| Major findings: Of operations Genital peritonitis |
| 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Paul Forgrave (M.D. or other)

Address 931 Faraon St Joseph Mo Date signed 4-23-45

1377

(Licensed Embalmer's Statement on Reverse Side)

## 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 H. H. Crawford

Licensed Embalmer No. 1824

P. O. Address Maund City 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.**