

FILED MAY 28 1945  
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 382

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Springfield Baptist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 weeks**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

**Reba Adamson**

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 **Married**  
6. (b) Name of husband or wife **Eddie Adamson**  
6. (c) Age of husband or wife if alive **47** years  
7. Birth date of deceased **10-20-1900**  
(Month) (Day) (Year)

8. AGE: Years **44** Months **6** Days **18**  
If less than one day hr. min.

9. Birthplace **Lawrence Co. Mo. A**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Robert Williams**  
13. Birthplace **Lawrence Co. Mo. O**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Dora Mason**  
15. Birthplace **Lawrence Co. Mo. O**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Eddie Adamson**  
(b) Address **Evanton Mo.**

17. (a) **Buried** (b) Date thereof **5-10-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial **Shilo**

18. (a) Signature of funeral director **M. P. Modrup**  
(b) Address **ash home**

19. (a) **5-10-45** (b) **Dr W E Haulley**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lawrence**  
(c) City or town **Evanton**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **6**  
(If rural, give location)  
(e) Citizen of foreign country? **1** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **8**  
year **1945** hour **1** minute **35** A.M.

21. I hereby certify that I attended the deceased from **4-24** 19**45** to **May 8** 19**45**  
that I last saw her alive on **May 8** 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Metastatic Carcinoma**  
Due to **Carcinoma of breast removed 4 yrs ago.**  
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?

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

23. Signature **H. P. Modrup** (M. D. or other)  
Address **Springfield, Mo** Date signed

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

*E. R. Leumar*

Licensed Embalmer No. *3297*

P. O. Address *Miller 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.**

*P*