

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20439

FILED JUL 12 1945
Registration District No. 240

Primary Registration District No. 4229

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Howard
(b) City or town New Franklin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 4 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM PRICE ADAMS

3. (b) If veteran, name war: 1 3. (c) Social Security No. 1

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Sarah M. Stanley 6. (c) Age of husband or wife if alive see years
7. Birth date of deceased June 9 - 1862 (Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 23 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Charles Adams
13. Birthplace Not Known (City, town, or county) (State or foreign country)
14. Maiden name Sarah Adams
15. Birthplace Not Known (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Suedel Crowley
(b) Address Fayette Mo. R.R. 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation Fayette Cemetery
18. (a) Signature of funeral director C. L. Reunlan
(b) Address New Franklin Mo.
19. (a) 6-7-1945 (Date received local registrar) (b) Emmett W. Miller (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
(c) City or town New Franklin (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 June day 2 year 1945 hour 10 minute P.M.

21. I hereby certify that I attended the deceased from Oct 8 1940 to June 2 1945
that I last saw him alive on June 2 1945
and that death occurred on the date and hour stated above.

Immediate cause of death ca of prostate Duration 2 years

Due to

Due to

Other conditions arthritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations 5/11
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 Y. L. Chamberlain (M. D. or other)
Address New Franklin Mo. Date signed 6-5-45

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 7/11/45

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.