. S. No. 2
0M—8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr Judd

State File No. 25233

FILED JUL 18 1945

Registration District No. 581 Primary Registration District No. 6179 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Pollock - Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson Twp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 40 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Sullivan
(c) City or town Pollock - Rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Adeline Clarke Adams
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Fml
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife M. N. Adams
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased 3 (Month) 17 (Day) 1880 (Year)
8. AGE: Years 60 Months 1 Days 6 If less than one day hr. min.
9. Birthplace Avilla (City, town, or county) Mo (State or foreign country)
10. Usual occupation house wife
11. Industry or business

FATHER
12. Name Rueben H Sheldon
13. Birthplace New York State (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Baston
15. Birthplace Jasper Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant M. N. Adams
(b) Address Pollock - Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Wilson Cem.
18. (a) Signature of funeral director Schoenes
(b) Address Milan Mo
19. (a) May 4-45 (Date received local registrar) (b) Mrs. L. D. Green (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23 year 1945 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 23, 1945, to 19
that I last saw her alive on April 23 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	3 hours
Due to Arteriosclerosis & hypertension	years
Due to Chronic glomerulo-nephritis	years

Other conditions
(Include pregnancy within 3 months of death)

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

Major findings:
Of operations
Of autopsy

130

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? Means of injury

23. Signature Lehar J Judd (M. D. or other) D.O.
Address Pollock, Mo Date signed 4/24/45

1190

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-45-1167
Date Filed JUL 17 1945

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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan, 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.