

FILED OCT 4 1945

Registration District No.

Primary Registration District No.

1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether years, months or days)
In this community 60 years

3. (a) PRINT FULL NAME Samuel H. Adams

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Josephine L. Adams 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased June 25 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 2 18 hr. min.

9. Birthplace Buffalo New York
(City, town, or county) (State or foreign country)

10. Usual occupation retired veterernarian

11. Industry or business

12. Name John Q. Adams
13. Birthplace unknown New York
(City, town, or county) (State or foreign country)
14. Maiden name Susan Randal
15. Birthplace unknown New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Samuel H. Adams
(b) Address 301 South 9th
17. (a) burial (b) Date thereof 9/ 15/45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn

18. (a) Signature of funeral director Heaton Beale & Bowman
(b) Address 319 South 10th ST. JOSEPH
19. (a) 9/18/45 (b) H. H. Torga
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 301 South 9th
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13th
year 1945 hour 7 minute 35 AM

21. I hereby certify that I attended the deceased from 26 1945 to Sept 13 1945
that I last saw him alive on Sept 12 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Auto dilatation Duration

Due to Auto dilatation

Due to Cardio-Renal emphysema

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

Major findings:
Of operations

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 H. H. Torga (M. D. or other) DO
Address 418 K. Hospital Date signed 9/16/45

By H. H. Jorgensen
Kirk, Bldg.

2-4660

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 Herald T. Wade

Licensed Embalmer No. 4172

P. O. Address St. Joseph

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.