

FILED OCT 22 1945

Registration District No. **62**

Primary Registration District No. **5240**

1. PLACE OF DEATH:

(a) County **Cedar**
(b) City or town **Washington Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **1111**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Mo.** (Specify whether years, months or days)
In this community **6 Mo.**

3. (a) PRINT FULL NAME **Charles Henry Adair**

3. (b) If veteran, **✓** **3. (c) Social Security** **✓**
name war. No.

4. Sex **M** **5. Color or race** **W** **6. (a) Single, widowed, married,** **divorced**
6. (b) Name of husband or wife **Lilly Adair** **6. (c) Age of husband or wife if** **alive** **X** **years**
7. Birth date of deceased **Oct 19, 1876** (Month) (Day) (Year)

8. AGE: Years **68** Months **10** Days **22** If less than one day hr. min.

9. Birthplace **Adams Co. Ill.** (City, town, or county) (State or foreign country)

10. Usual occupation **Auctioneer**

11. Industry or business

12. Name **C.C. Adair**
13. Birthplace **Ill.** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Jane** (State or foreign country)
15. Birthplace **Waukegan Ill.** (City, town, or county) (State or foreign country)

16. (a) Informant **C.W. Adair**

(b) Address **St. Jackson, Mo.**

17. (a) Burial **(b) Date thereof** **Sept 19-46** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Jackson**

18. (a) Signature of funeral director **Church & Neale**

(b) Address **St. Jackson, Mo.**

19. (a) 9-27-45 **(b) General Harrison** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Cedar**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. **Washington Twp.** (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 **16** year **1945** hour minute M.

21. I hereby certify that I attended the deceased from **Sept. 14** **1945** to **Sept. 16** **1945**
that I last saw him alive on **Sept. 15** **1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** **12 days**
Had second cerebral hem.
Due to **Sept. 15**

Due to

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 **St. Jackson, Mo.** (M. D. or other)
Address **St. Jackson, Mo.** Date signed **9-16-45**

REC

D

Office No. 7,

Dis

Date Filed

9-43-1018

1781

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

working under my personal supervision.

Registered Apprentice No.

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.