

STANDARD CERTIFICATE OF DEATH

State File No. 36851

Registration District No. 55

Primary Registration District No. 3011

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(N outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Atwood Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Entire life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll
(c) City or town Carrollton
(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 _____

3. (a) PRINT FULL NAME EDWARD ADKINS

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Belle Adkins 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 7 1885 (Month) (Day) (Year)

8. AGE: Years 60 Months 10 Days 23 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER
12. Name Wm Adkins
13. Birthplace Carroll Co. Mo (City, town, or county) (State or foreign country)
14. Maiden name Addie Henry
15. Birthplace Carroll Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Wm Hughes

(b) Address Carrollton Mo

17. (a) Burial (b) Date thereof 12-4-45 (Month) (Day) (Year)

(c) Place: burial or cremation Adkins Cem

18. (a) Signature of funeral director Stanley Gibson

(b) Address Carrollton Mo

19. (a) 12-2-45 (Date received local registrar) (b) Mrs. Herbert Calvert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30 year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-30, 1945, to 11-30, 1945; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Depressed fracture of skull Duration 2 hrs.

Due to _____
Due to _____

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

Major findings: Of operations _____ Of autopsy 1860 39

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) Accident 117

(b) Date of occurrence 12-30-45

(c) Where did injury occur? Carrollton Carroll Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place, fell from roof of building

While at work? yes (Specify type of place) while working (e) Means of injury on roof of public store

23. Signature W.S. Atwood (M. D. or other)

Address Carrollton Mo Date signed 12/2/45

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

RECEIVED

District Health Officer No. 5,

District File Number.....

Date Filed 12-12-41

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 Ben W Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, 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.