

No. 2  
-2-43  
-17-39

X35697

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI

36953

BUREAU OF THE CENSUS  
FILED Nov 20 1945

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 243

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital (1)  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway <sup>14</sup>

(c) City or town Holt Summit  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location) 1

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Phillip Thomas Adkison

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

4. Sex Male (D) 5. Color or race white 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Emma Farmer 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased September 2 1864  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>	<u>2</u>	<u>2</u>	hr. _____ min. _____

9. Birthplace Callaway County, Missouri (1)  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Enoch Adkison

13. Birthplace Indiana <sup>1</sup>  
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Jane Lawson

15. Birthplace Indiana <sup>1</sup>  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Emma Adkison

(b) Address Holt Summit, Missouri

17. (a) Burial (b) Date thereof Nov-6-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation River View Cemetery

18. (a) Signature of funeral director Thorpe Gordon

(b) Address Jefferson City, Missouri

19. (a) 11-9-45 (b) [Signature]  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 4  
year 1945 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct 26  
1945 to Nov 4 1945  
that I last saw him alive on Nov 4 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Hy postatic pneumonia

Due to Intestinal obstruction <sup>10 day</sup>

Due to Valvular + intestinal hemorrhage <sup>10 day</sup>

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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. Kanagawa (M, D, or other) MD  
Address 129 E High St Date signed 11/6/45

Duration

2 day

10 day

10 day

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

1431

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 0,

District File Number.....

Date Filed 11-18-45

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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 Leod P. Dulle

Licensed Embalmer No. 3890

P. O. Address Jefferson City, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1000  
Registrar's No. 243

Registration District No. 77 Primary Registration District No. 3016

1. PLACE OF DEATH:  
(a) County cole  
(b) City or town Jefferson city  
(If outside city or town limits write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days)  
3. (a) PRINT FULL NAME Phillip J. Adkison  
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 m  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 2 (Month) (Day) (Year)

8. AGE: Years 81 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_, year 1945, hour \_\_\_\_\_, minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to Intestinal obstruction 10 days  
Due to \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 122K

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 W Kanagawa (M. D. or other) MD  
Address 129 E High St Date signed 11/24/45

SUPPLEMENTARY

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

30953