

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

37502

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH

(a) County Gasconade
(b) City or town Gasconade
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2706 Penn Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Rush Adams

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

6. (c) Age of husband or wife if

7. Birth date of deceased

Oct

5 1874

8. AGE:

Years

Months

Days

If less than one day

71

0

14

hr. min.

9. Birthplace

Gasconade Mo

(City, town, or county) (State or foreign country)

10. Usual occupation

Bellevue Home Mason

11. Industry or business

Contractor

12. Name

J. C. Adams

13. Birthplace

Gasconade Mo

(City, town, or county) (State or foreign country)

14. Maiden name

Wilkinson

15. Birthplace

Gasconade Mo

(City, town, or county) (State or foreign country)

16. (a) Informant

Mrs L. Eads

(b) Address

2706 Penn Ave

17. (a)

Burial

(b) Date thereof

10-22-45

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Osborne Memorial

18. (a) Signature of funeral director

Thomuel Nelson

(b) Address

305 W 4th St

19. (a)

10-24-45

(b)

Ed Jones

(Date received local registrar)

(Burial or cremation)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade
(c) City or town Gasconade
(If outside city or town limits, write "RURAL")
(d) Street No. 2706 Penn Ave
(If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 19
year 1945 hour 11 minute 23 P M.

21. I hereby certify that I attended the deceased from July 1943 to Oct 19 1945;
that I last saw him alive on Oct 19 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary and intestinal tuberculosis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 136

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 John W. Jones (M. D. or other)

Address John W. Jones Date signed 10/24/45

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Craig Thornhill

Licensed Embalmer No.

3590

P. O. Address.....

Springfield, 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.