

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 8 1946

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1371

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:
2011 Howard
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 12 years
years, months or days)

3. (a) PRINT FULL NAME Edwin Clarence 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
6. (b) Name of husband or wife Ida Belle Adams 6. (c) Age of husband or wife if, alive 67 years
7. Birth date of deceased April 29 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 20 If less than one day
hr. _____ min. _____

9. Birthplace Clarksdale Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation retired farmer

11. Industry or business

12. Name Thomas Perry Adams
13. Birthplace Unknown unknown
(City, town, or county) (State or foreign country)
14. Maiden name Amelia Bennett
15. Birthplace unknown Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edwin C. Adams
(b) Address 2011 Howard Street,

17. (a) burial (b) Date thereof 12/22/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bethel Cemetery Cosby

18. (a) Signature of funeral director Heaton Belle & Bowman

(b) Address St. Joseph, Mo.

19. (a) Dec 26 - 1945 (b) J. H. H. H. H. H.
(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. 2011 Howard
(If rural, give location) //
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19th
year 1945 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from 12/14/45 to 12/19/45
that I last saw him alive on 12/19/45 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage
Due to chronic hypertension 1 yr.
upper resp. infection 2 wks.
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? Mo.

While at work? _____ (Specify type of place) (e) Means of injury 0

23. Signature W. H. H. H. H. (M. D. or other) MD.
Address Kirkpatrick Bldg. Date signed 12/20/45

Mr. Wayne H. Lottaker
Kirk. Bldg.

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 Frank A. Brown

Licensed Embalmer No. 1710

P. O. Address St. Joseph 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.