. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

41351

State File No.

FILED JAN 5 1946

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 126

1. **PLACE OF DEATH:**
(a) County HOWELL
(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
RESIDENCE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO. (Specify whether
In this community 40 YEARS. years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State MISSOURI (b) County HOWELL
(c) City or town WEST PLAINS,
(If outside city or town limits, write "RURAL")
(d) Street No. 417 LEYDA AVE
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME OTIS ADAMS
3. (b) If veteran, name war
3. (c) Social Security No. 496-03-4596

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife LAURA CORDELL ADAMS
6. (c) Age of husband or wife if alive years
7. Birth date of deceased JAN. (Month) 18, (Day) 1900 (Year)

8. AGE: Years	Months	Days	If less than one day
45	9	29	hr. min.

9. Birthplace HOWELL Co., (City, town, or county) Mo. (State or foreign country)
10. Usual occupation TRUCK DRIVER
11. Industry or business FRISCO TRANSPORTATION Co

MOTHER FATHER
12. Name JOHN WESLEY Adams
13. Birthplace OREGON Co., (City, town, or county) Mo. (State or foreign country)
14. Maiden name CAROLINE HIGHFILL
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant MRS. LAURA ADAMS.
(b) Address WEST PLAINS, Mo.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Nov. 21, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation HOWELL VALLEY CEM. HOWELL TWP., HOWELL Co.
18. (a) Signature of funeral director Hal Thornburgh
(b) Address WEST PLAINS, Mo.
19. (a) 11-26-45 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month NOV. day 17, year 1945 hour 2: minute P. M.
21. I hereby certify that I attended the deceased from Nov. 8th, 1945, to Nov. 17th, '45, 19; that I last saw him alive on Nov. 17th, '45. 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Angina, Pectoris, acute attack	20 M
Due to: Angina Pectoris, Pseudo,	
Due to: Gastritis, acute. Catarrhal	
Other conditions (Include pregnancy within 3 months of death): Influenza, acute	1 week

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) No
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Hal Thornburgh (M. D. or other)
Address West Plains, Mo. Date signed 11/23/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5,

District File Number 1945-462

Date Filed 12-29-45.

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 Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.