No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 7 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 608

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 960

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 WEEKS. (Specify whether years, months or days)
In this community ALL OF LIFE.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI. (b) County
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 1421 HOGAN ST.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country NONE.

3. (a) PRINT FULL NAME JOHN F. MCADAMS

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 SINGLE

6. (b) Name of husband or wife NONE.

6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased NOV. (Month) 6TH. (Day) 1871. (Year)

8. AGE: Years 74 Months 2 Days 21 If less than one day — hr. — min.

9. Birthplace ST. LOUIS (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation FORMERLY WATCHMAN

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace IRELAND. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace IRELAND. (City, town, or county) (State or foreign country)

16. (a) Informant Leo F. C. Adams Sr.
(b) Address 4122 A. FARLIN AVE.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 30TH, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEMETERY.

18. (a) Signature of funeral director Buckland Bud Co.
(b) Address 1827 HOGAN ST.

19. (a) JAN 29 1946 (Date received local registrar) (b) J. T. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27th year 1946 hour 6:15 minute P M.

21. I hereby certify that I attended the deceased from 1/19/46, 19..., to 1/27/46, 19...; that I last saw him alive on 1/27/46, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure — Duration

Due to Hypertensive arteriosclerotic Heart disease

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

23. Signature X. D. Jorgensen M.D. 1515 Lafayette 1/28/46 (M.D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 John Ogonoski

Licensed Embalmer No. 3398

P. O. Address ——

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.