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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 21 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1146

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5508

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C. Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2601 Highland (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 yr. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town K.C. Mo (If outside city or town limits, write "RURAL") 3

(d) Street No. 2601 Highland (If rural, give location) 8 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

3. (a) PRINT FULL NAME John Damon Adrine

3. (b) If veteran, name war No

3. (c) Social Security No. 496-09-1490

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced M. 1

6. (b) Name of husband or wife Elnora Adrine

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased May (Month) 19 (Day) 1908 (Year)

8. AGE: Years 37 Months 7 Days 5 If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business

FATHER
12. Name John Adrine
13. Birthplace Ga. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sallie Whitehead
15. Birthplace Ga. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jonie Calhoun

(b) Address 2601 Highland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-46 (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cem

18. (a) Signature of funeral director H B Moore

(b) Address 1820 E 18 st

19. (a) 12-31-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 24 year 1945 hour 7 am minute M.

21. I hereby certify that I attended the deceased from Oct. 31, 1940 to Dec. 24, 1945 that I last saw him alive on Dec 24, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Gastro-Enteritis + Caseous Pneumonia

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13 lb

Of autopsy no

Duration

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 L. W. Booker (M. D. or other) MD

Address 2028 Vine St. Date signed 12/31/45

(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 H B Moore

Licensed Embalmer No. 2410

P. O. Address 1820 E 18 st

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.