

**FILED FEB 7 1946**  
Registration District No. **72**

Primary Registration District No. **5289**

**1. PLACE OF DEATH:**  
(a) County Clay  
(b) City or town Claycoma, Gallopier Mo.  
(c) Name of hospital or institution:  
rural /  
(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 4 years  
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Clay 24  
(c) City or town Claycoma  
(If outside city or town limits, write "RURAL")  
(d) Street No. rural  
(If rural, give location)  
(e) Citizen of foreign country? X (Yes or No)  
If yes, name country X

**3. (a) PRINT FULL NAME** Mrs. Elizabeth Budd Adams  
**3. (b) If veteran,** name war no. **3. (c) Social Security** No. no.  
**4. Sex** female **5. Color or** race white  
**6. (a) Single, widowed, married,** divorced Widowed?  
**6. (b) Name of husband or wife.** E. E. Adams **6. (c) Age of husband or wife if** alive dec. years  
**7. Birth date of deceased.** January 17 1857  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month January day 10  
year 1946 hour 9:00 minute A. M.  
**21. I hereby certify that I attended the deceased** from May 5  
1944 to Jan 10, 1946  
that I last saw h. a alive on Jan 4, 1946  
and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
88 11 24 hr. min.

Immediate cause of death  
Senile Arterio Sclerosis  
with Cerebral  
hemorrhage  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions general Arterio  
(Include pregnancy within 3 months of death)

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

**PHYSICIAN**  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Gen  
Underline the cause to which death should be charged statistically.

**10. Usual occupation** at home,  
**11. Industry or business** X  
**12. Name** Phillip Hull  
**13. Birthplace** New York  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Sophronia Williams  
**15. Birthplace** New York  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Clyde L. Adams,  
**(b) Address** Claycoma, Missouri  
**17. (a) Removal** (Burial, cremation, or removal) **(b) Date thereof.** 1-10-46  
(Month) (Day) (Year)  
**(c) Place: burial or cremation** Cordova, Illinois

**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) (c) Means of injury \_\_\_\_\_

**18. (a) Signature of funeral director** Stine & McClure,  
**(b) Address** 3235 Gillham Plaza, K. C., Mo.  
**19. (a) Jan 10<sup>th</sup> 1946 **(b) Baulah Kitchen**  
(Date received local registrar) (Registrar's signature)**

**23. Signature** E. H. Ferlingu, (M. D. or other)  
**Address** 311 Maple Alley **Date signed 1/10-46**

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

439

Dr. E. H. Zellinger

*Angela B. Kelly*

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-5-46

FEB 18 1946

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 *[Signature]*

Licensed Embalmer No. 1415

P. O. Address B. C. [Signature]

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.