

FILED JAN 28 1946

State File No. _____

Registration District No. 277

Primary Registration District No. 5951

Registrar's No. 68

1. PLACE OF DEATH

(a) County Pike
(b) City or town Indian Surf, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

Ray Johnson Adams

3. (b) If veteran, name war Y

3. (c) Social Security No. yes

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife Ida Wright Adams 6. (c) Age of husband or wife if alive Y years
7. Birth date of deceased Apr. 26 1885
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace Pike Co MO
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Wm S. Adams
13. Birthplace Pike Co MO
(City, town, or county) (State or foreign country)
14. Maiden name Roxie Johnson
15. Birthplace Pike Co MO
(City, town, or county) (State or foreign country)

16. (a) Informant H. L. Adams
(b) Address Curryville MO

17. (a) Burial (b) Date thereof Dec 29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green MO

18. (a) Signature of funeral director Gracie Bonifred

(b) Address Bowling Green MO

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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pike
(c) City or town Curryville Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

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

Immediate cause of death gun shot in head inflicted by self
Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations 164C
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) suicide
(b) Date of occurrence December 27 1945
(c) Where did injury occur? in home Pike Co
(City or town) (County) (State)
(d) Did injury occur in _____ about home, on farm, in industrial place, in public place?
in bed Room

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

23. Signature J. A. Goodin (M.D. or other) _____
Address Curryville MO Date signed 12-29-45

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

5-2
-43
-39
637823

OCT 15 1947

RECEIVED
District Health Officer No. 10
District File Number 1-46-144
Date Filed JAN 24 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 Grace M. Rankin

Licensed Embalmer No. 2284

P. O. Address Bowling Green

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27-2
Registrar's No. 268

Registration District No. 277 Primary Registration District No. 5951

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Rural Indian Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days
3. (a) PRINT FULL NAME Ray J. Adams
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced un
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country) MO

10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb. 1945
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____
Due to _____
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?
While at work? _____ (Specify type of place) _____ (c) Means of injury _____
23. Signature S. A. Spadin Barones
Address Louisiana Mo Date signed _____

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

SUPPLEMENTARY

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