DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10054

FILED MAR 27 1946

Registration District No. 200 — Primary Registration District No. 3041 — Registrar's No. 45

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

1. PLACE OF DEATH

(a) County: Macon

(b) City or town: Macon
(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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Macon 61

(c) City or town: Macon 3
(If outside city or town limits, write "RURAL")

(d) Street No. 12
(If rural, give location)

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

If yes, name country ____

3. (a) PRINT FULL NAME: Thomas Adams

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: Male

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife ____

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

7. Birth date of deceased: May (Month) 9 (Day) 1869 (Year)

8. AGE: Years 76 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace: Macon (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business ____

MOTHER / FATHER

12. Name: Frank Adams

13. Birthplace: Mo (City, town, or county) (State or foreign country)

14. Maiden name: Amanda Woods

15. Birthplace: Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Rosa B. Adams

(b) Address: Macon Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/46 (Month) (Day) (Year)

(c) Place: burial or cremation: Woodlawn Cem

18. (a) Signature of funeral director: Albert S Kimm

(b) Address: Macon Mo

19. (a) 2/28/46 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

185

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22 year 1946 hour 7:30 minute P M.

21. I hereby certify that I attended the deceased from Feb 13, 1946 to Feb 22, 1946 that I last saw him alive on Feb 11, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Pneumonia	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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: Dr C D Edwards (M. D. or other)

Address: Mason, Mo. Date signed 2/26/46

MAR 14 1956

RECEIVED
District Health Officer No. 10
District File Number 3-46-555
Date Filed MAR-1-9-1946

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 Albert S Kennon

Licensed Embalmer No. 75-1

P. O. Address Macon Ga

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.

No. 2B
—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 43

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Macon
(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)

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

3. (a) PRINT FULL NAME Thomas Adams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased May 9 (Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May Day 12 year 1946 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to Lobar Pneumonia	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 10 8

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 Dr C A Edwards (M. D. or other)
Address Date signed

SUPPLEMENTARY 12

8972 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

10054