

**FILED** APR 6 1948

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3169 N. Main St  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days 1

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64  
(c) City or town Hannibal 3  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. 3169 N. Main  
(If rural, give location) 3  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Sarah Jane Adams

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive \_\_\_\_\_ years (Day) (Year)

7. Birth date of deceased January 15 1862  
(Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name James M. Skinner  
13. Birthplace \_\_\_\_\_ Ky (State or foreign country)  
14. Maiden name Elizabeth Johnson  
15. Birthplace \_\_\_\_\_ Ky (State or foreign country)

16. (a) Informant Thomas Adams  
(b) Address 3169 N. Main Hannibal MO

17. (a) Cremation (b) Date thereof March 5, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director James Ollmsted  
(b) Address Hannibal, MO

19. (a) 3-8-46 (b) W. E. M. Lucke  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20 year 1946 hour \_\_\_\_\_ minute 11 50 P M.

21. I hereby certify that I attended the deceased from Jan 1946 to 3-2 1946  
that I last saw him alive on Jan 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Mycobacterium  
Due to Centropus calaw

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 9301  
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 2/1  
(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 W. E. M. Lucke (M. D. or other) \_\_\_\_\_  
Address Hannibal, MO Date signed 3-8-46

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

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**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.....

Licensed Embalmer No. *3889*.....

P. O. Address *Hannibal, Mo*.....

**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.**