

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11879**

FILED APR 10 1946

Registration District No. **523**

Primary Registration District No. **4474**

Registrar's No. **62**

1. PLACE OF DEATH:

(a) County **SALINE**
(b) City or town **SWEET SPRINGS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
104 West Virginia Ave
(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)

3. (a) PRINT FULL NAME **MARY ADAINE Johnson ADAMS**

3. (b) If veteran, name war **✓** 3. (c) Social Security No. **✓**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **Thos ADAMS** 6. (c) Age of husband or wife if alive **82** years
7. Birth date of deceased **FE 13 1869**
(Month) (Day) (Year)

8. AGE: Years **77** Months **17** Days **17** hr. min.

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

10. Usual occupation **HOUSE WIFE**

11. Industry or business **AT HOME**

12. Name **J. W. Johnson**

13. Birthplace **VA**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY MAE LANE**

15. Birthplace **VA**
(City, town, or county) (State or foreign country)

16. (a) Informant **Tomm Adams**

(b) Address **Sweet Springs Mo**

17. (a) **BURIAL** (b) Date thereof **3-7-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FAIRVIEW CEMETERY**

18. (a) Signature of funeral director **R. C. CARTER**

(b) Address **SWEET SPRINGS, MO**

19. (a) **3/7/46** (b) **Holly Andrew**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **SALINE 97**
(c) City or town **SWEET SPRINGS** 3
(If outside city or town limits, write "RURAL")
(d) Street No. **104 W. VIRGINIA** 0
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **5**
year **1946** hour **7** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **Mar 1**
1946 to **Mar 5**, **1946**
that I last saw **her** alive on **March 4**, **1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchio-pneumonia**

Due to **Fibrous Myocarditis**

Due to **Exhaustion by Carcinoma of right breast**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **Carcinoma of right breast**
Of autopsy **none**

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? (c) Means of injury **-**

23. Signature **A. H. Ringan** (M. D. or other)
Address **Sweet Springs, Mo** Date signed **3-6-46**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

4-9-46

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

R. C. Carter

Licensed Embalmer No.

00713

P. O. Address

Shut Up

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.