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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1943
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16135

State File No. _____

Registrar's No. 391

Registration District No. 89

Primary Registration District No. 53-284125

1. PLACE OF DEATH:

(a) County Crawford
 (b) City or town Leesburg 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
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
 (c) City or town Leesburg (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 BENJAMIN JOSEPH ADAMS
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 28th
 year 1946 hour 4 minute 30 P.M.
 21. I hereby certify that I attended the deceased from April 20 1946 to April 28 1946
 that I last saw him alive on April 27 1946
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced, widower
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years

Immediate cause of death: acute endocarditis
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

7. Birth date of deceased: May - 7 - 1862
 (Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 21
 If less than one day hr. min.

PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

10. Usual occupation: Farmer

11. Industry or business _____
 12. Name: Joseph Adams
 13. Birthplace: Leesport Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name: Lucy Childers
 15. Birthplace: Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant: Eva Adams
 (b) Address: Leesburg Mo.

17. (a) Burial (b) Date thereof: 4-30-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation: Leesburg Mo.

18. (a) Signature of funeral director: Elbert Long
 (b) Address: Leesport Mo.

19. (a) 4-29-46 (b) W. J. Irwin M.D.
 (Date received local registrar) (Registrar's signature)

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?
 at home (Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature: W. J. Irwin (M. D. or other)
 Address: Leesburg Mo. Date signed: 4-29-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,
District File No. 646352
Date Filed 6-1-46

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 Elbert Ed Long
Licensed Embalmer No. 3504
P. O. Address Courbow 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. 397

Registration District No. 89

Primary Registration District No. 4125

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

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Keokuk
(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 Benjamin J. Adams

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July
year 1946 hour _____ minute _____ M.

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

4. Sex m

5. Color or race w

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

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

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

8. AGE: Years 83 Months 14 Days _____ If less than one day _____ hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 29, 46 (b) N. F. Swinmire
(Date received local registrar) (Registrar's signature)

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)
_____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Date signed _____

SUPPLEMENTARY

16135