

S. No. 2
M-5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 11 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36095**
Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **1340**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(c) Name of hospital or institution:
At Home- 1724 North 11th. Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community **Entire lifetime.**
years, months or days

3. (a) PRINT FULL NAME **MALVERN CLIFFORD ADAMS.**
3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color **White** 6. (a) Single, widowed, married, divorced **Widower**
7. Birth date of deceased **February 14th 1868**
(Month) (Day) (Year)

8. AGE: Years **78** Months **9** Days **17** If less than one day
-- hr. -- min.

9. Birthplace **DeKalb- Missouri, Farming.**
(City, town) (State or foreign country)

10. Usual occupation

11. Industry or business **General Farming.**

12. Name **Thomas Perry Adams.**

13. Birthplace **Unknown.**

14. Maiden name **Amelia Bennett.**

15. Birthplace **Unknown.**

(City, town, or county) (State or foreign country)

16. (a) Informant **Roy Adams- (Son)**

(b) Address **1724 North 11th. Street**

17. (a) **Burial** (b) Date thereof **Dec-2nd-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bethel Cemetery.**

18. (a) Signature of funeral director **W. E. R. Sidenfaden**

(b) Address **602 South 10th. Street.**

19. (a) **Dec. 4, 1946** (b) **E. C. Jenkins by J. J. M. M.**
(Date received local registrar) (Registrar's signature)

(This received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **1724 North 11th. Street**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov--** day **30th.**
year **1946** hour **6** minute **45** A. M.

21. I hereby certify that I attended the deceased from **June 1** to **Nov. 29**
that I last saw him alive on **Nov. 29**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**
Duration **17 hours.**

Due to **Essential Hypertension**

Due to **Arteriosclerosis**

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

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?

(e) While at work (Specify type of place) (f) Means of injury

23. Signature **W. E. R. Sidenfaden** (M. D. or other)

Address **602 South 10th. Street.** Date signed **12/3/46**

342 (Licensed Embalmer's Statement on Reverse Side)

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.....

Mollie E. Sidenfaden Fox

Licensed Embalmer No.....

4235

P. O. Address.....

St. Joseph, 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.