

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3946

State File No.

FILED MAR 3 1947

Registration District No.

Primary Registration District No. 1000

Registrar's No. 266

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Joseph's Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 hr.
(Specify whether
In this community 27 years.
years, months or days)

3. (a) PRINT FULL NAME Charles Melvin Adams

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

4. male 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
7. Birth date of deceased 2-23-47
(Month) (Day) (Year)

8. AGE: Years Months Days If less-than one day
1 0 0 0 18 hr. 45 min.

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

10. Usual occupation Newborn

11. Industry or business None

12. Name Harold Franklin Adams

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

14. Maiden name Elaine Mae Beck

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

16. (a) Informant Mrs. Elaine Adams

(b) Address 1918 So. 18 St., City

17. (a) Burial (b) Date thereof 2-24-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph's Cemetery

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

(b) Address St. Joseph, Mo.

19. (a) 2-24-47 (b) H. B. Jenkins
(Date 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. 1918 So. 18th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23
year 1947 hour 12:05 minute — P. M.

21. I hereby certify that I attended the deceased from 2-23-47 to 12:05 PM - 2-23-1947
that I last saw him alive on 2-23-47
and that death occurred on the date and hour stated above.

Immediate cause of death Transverse Presentation
Pulmonary Hemorrhage

Due to —

Due to —

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 —
(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 W. E. R. Lidenfald (M. D. or other) —
Address St. Joseph Date signed 2-28-47

(Licensed Embalmer's Statement on Reverse Side)

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

STATEMENT BY LICENSED EMBALMER

Did not Embalm

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 Flor

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.