

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

16026

FILED MAY 8 1947

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 91

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1175 So. Lincoln
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME JAMES MICHEAL ADAMS

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mildred Strong Adams 6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased June-21-1901
(Month) (Day) (Year)

8. AGE: Years 45 Months 10 Days 5 If less than one day
hr. _____ min. _____

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

10. Usual occupation unemployed

11. Industry or business

12. Name John Elias Adams
13. Birthplace Saline Co MO
(City, town, or county) (State or foreign country)
14. Maiden name Annie Marie Brown
15. Birthplace Saline Co MO
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. M. Adams

(b) Address Marshall MO

17. (a) Burial (b) Date thereof 4-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Marshall MO
Ridge Park Cem.

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall MO

19. (a) April 30, 1947 (b) Lidney T. Gray
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Saline 97
(c) City or town Marshall 1
(If outside city or town limits, write "RURAL")
(d) Street No. 1175 So. Lincoln 2
(If rural, give location)
(e) Citizen of foreign country? MO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26 24
year 1947 hour 5 minute 30 A. M.

21. I hereby certify that I attended the deceased from 1935
_____, 19____, to April 26, 1947
that I last saw him alive on April 10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage Duration sudden

Due to Infection of lung from working at rock

Due to Crushed lung in fall of lung NO. 7.B. 15 yrs.

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

Major findings: _____

Of operations NO 13 Pa

Of autopsy NO

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)
(c) Means of injury _____

23. Signature H. B. Partington (M. D. or other) _____
Address Marshall MO Date signed 4-29-47

RECEIVED

District Health Officer No. 2

District File Number

Date Filed

5-7-47

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

Harry Herschberger

Licensed Embalmer No. *4357*

P. O. Address *Marshall, 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.