

S. No. 2
M-5-43
5-17-39
I X36571

FILED JUL 10 1947

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 45

1. PLACE OF DEATH:

(a) County DENT

(b) City or town SALEM
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
NONE
(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 MISSOURI (b) County DENT 33

(c) City or town SALEM 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 1

(e) Citizen of foreign country? NO (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME HAROLD DEE ADKINS

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 25
year 1947 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from June 25
to June 25, 1947

4. Sex MO 5. Color or race W

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

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

7. Birth date of deceased JUNE 25 1947
(Month) (Day) (Year)

that I last saw her alive on June 25
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
7 1/2 months

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

Due to Congenital Heart Disease

Due to _____

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

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

10. Usual occupation INFANT

11. Industry or business _____

MOTHER FATHER { 12. Name DEE LESTER ADKINS

{ 13. Birthplace TEXAS CO. MISSOURI
(City, town, or county) (State or foreign country)

{ 14. Maiden name DOROTHY MALONE

{ 15. Birthplace DENT CO. MISSOURI
(City, town, or county) (State or foreign country)

Major findings: _____

Of operations _____

Of autopsy 700 1578

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

16. (a) Informant Lester Adkins

(b) Address SALEM, MO.

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? _____

17. (a) BURIAL (b) Date thereof 6/26/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MORRISON CEM.

While at work? _____ (Specify type of place)

(e) Means of injury _____

18. (a) Signature of funeral director Carl L. James

(b) Address SALEM, MO.

19. (a) 7-1-47 (b) M. M. West, M.D. by M.S.
(Date received local registrar) (Registrar's signature)

23. Signature W. H. Dillman (M. D. or other) _____

Address SALEM MO Date signed 6-28-47

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

RECEIVED

District Health Officer No. 5,

District File Number 747317

Date Filed 7-8-47

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 *[Signature]*.....

Licensed Embalmer No.....

P. O. Address.....

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.