S. No. 2
OM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 4 1947
#34904

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32278

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9075

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 43 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. North-side ...Little Sisters of Poo Memorial
(If rural, give location) 3225 N. Florissant

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Adams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 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 July 14th, ? (Month) (Day) (Year)

8. AGE: Years 77? Months Days If less than one day hr. min.

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

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name James Adams
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Anna Burns
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 9-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director W. Richter
(b) Address 3500 Rutger St.

19. (a) SEP 30 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 27th year 1947 hour 3:40 minute P M.

21. I hereby certify that I attended the deceased from 3/15/47, 19..., to August 27th, 1947 that I last saw him alive on August 27th, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure	6 wks
Due to Arteriosclerotic Heart Disease	not known
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. Lowry Brown, M.D. (M. D. or other)
Address 1515 Lafayette Date signed 8/27/47

(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.....

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.