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DM—8-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 28 1947
Registration District No. 29

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33845
State File No.

Primary Registration District No. 5-175-

Registrar's No. 16

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

1. PLACE OF DEATH:
(a) County CAMDEN
(b) City or town BRANCH MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: (Residence)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community [redacted] 50 YRS

2. USUAL RESIDENCE OF DECEASED: 15
(a) State MISSOURI (b) County CAMDEN
(c) City or town BRANCH MO
(If outside city or town limits, write "RURAL") 0
(d) Street No. ..... (If rural, give location) 0
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME JAMES ATKINS 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 MARRIED

6. (b) Name of husband or wife HANNAH Adams 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased JUNE 6 1886 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
61	4	2	..... hr. ..... min.

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

10. Usual occupation FARMER

11. Industry or business .....

MOTHER FATHER
12. Name SAMUEL ADAMS O
13. Birthplace DALLAS Co MO (City, town, or county) (State or foreign country)
14. Maiden name SARAH [redacted] TURNER
15. Birthplace MEMPHIS TENN (City, town, or county) (State or foreign country)

16. (a) Informant MRS MOLLIE DUFF
(b) Address BUFFALO MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation HOPE WEC
18. (a) Signature of funeral director L B JONES
(b) Address BUFFALO M
19. (a) 10-16-47 (Date received local registrar) (b) [redacted] (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month OCT day 9
year 1947 hour 9 minute 45 P. M.

21. I hereby certify that I attended the deceased from Oct 1-47 ....., 19..., to Oct 9 ....., 19 47
that I last saw h[redacted] alive on 10-6 ....., 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal Lithiasis	N/6
Due to	
Due to	
Other conditions (Includes pregnancy within 3 months of death) NO	

Major findings:
Of operations NO
Of autopsy NO

131A

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, public place? .....
While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature E. E. Cleiborne M.D.
Address Crockett Mo Date signed 10/16/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File
Date Filed

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 Morris B. Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, 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.