

FILED JAN 2 1947
Registration District No. **2487**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution: **3018 East 59th Street**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 Weeks**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Florence L. Adams**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Female**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **J. W. Adams**

6. (c) Age of husband or wife if alive **29** years

7. Birth date of deceased: **10 29 1869**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
78	1	18	hr. min.

9. Birthplace **Sullivan County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Bennett M. Hollon**

13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Martin**

15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lottie L. Eason**

(b) Address **3018 East 59th Street**

17. (a) **Removal** (b) Date thereof **12-17-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Brookfield, Missouri**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **Kansas City, Missouri**

19. (a) **12-17-47** (b) **Heraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linnson**

(c) City or town **Brookfield**
(If outside city or town limits, write "RURAL")

(d) Street No. **427 Laclede Ave.**
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **17th** year **1947** hour **10** minute **A.** M.

21. I hereby certify that I attended the deceased from **Dec 8** 19**47**, to **Dec-17-1947**, that I last saw her alive on **Dec-17-1947**, and that death occurred on the date and hour stated above.

Duration **10 days**

Immediate cause of death **Cardiac De compensation**

Due to **Chronic Myocarditis**

Due to

Other conditions **Chronic Bronchitis**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **93.2**

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 **6**

23. Signature **Herald B. Clark** (M. D. or other)

Address **730 Rialto Bldg** Date signed **12-17-47**

PHYSICIAN

Underline the cause of which death should be charged statistically.

Dr. Clark

730 Rialto Bldg.

Ha 1483

before 1/30 P.M.

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 Dean Owens

Licensed Embalmer No. 4280

P. O. Address 918 Brooklyn
K.C., 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.