

No. 2
12-45
5-17-39
47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 20 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44525**
Registrar's No. **77**

Registration District No. **276** Primary Registration District No. **5947**

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

1. PLACE OF DEATH: **Phelps**
(a) County **Phelps**
(b) City or town **Rural St James township**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **40 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO** (b) County **Phelps**
(c) City or town **Rural St James Township**
(If outside city or town limits, write "RURAL")
(d) Street No. **r** (If rural, give location) **0**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **r**

3. (a) PRINT FULL NAME **Squire A Adams**
3. (b) If veteran, **✓** name war **✓**
3. (c) Social Security No **500-16-8021**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **12** day **11** year **1947** hour minute M.
21. I hereby certify that I attended the deceased from **Aug 13 1947** to **Dec 11 1947**
that I last saw him alive on **Dec 11 1947** and that death occurred on the date and hour stated above.

4. Sex **m** 5. Color or race **w**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Martha Adams**
6. (c) Age of husband or wife if alive **2** years
7. Birth date of deceased **July - 2 - 1890**
(Month) (Day) (Year)

Immediate cause of death **Frangene of lungs left**
Nov 13
Due to **abscess of left lung by metastasis**
Due to **Frangene of lungs left**
Nov 13
Duration **To Dec 11 1947**

8. AGE: Years Months Days If less than one day
57 **5** **9** hr. min.
9. Birthplace **Phelps Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **Trunk Driver**

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations **11/13**
Of autopsy **11/13**
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business
MOTHER FATHER { 12. Name **Squire A Adams**
13. Birthplace **Rt 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Schumaker**
15. Birthplace **MO**
(City, town, or county) (State or foreign country)

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?

16. (a) Informant **Martha Adams**
(b) Address **St James Mo**
17. (a) **Burial** (b) Date thereof **12-14-47**
(Burial, cremation or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Adams Cem**
18. (a) Signature of funeral director **Paul Zickler**
(b) Address **St James Mo**
19. (a) **Jan 9 48** (b) **Pora E. Birmingham**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury **0**
23. Signature **William H. Brewer M.D.** (M. D. or other)
Address **St James, Mo** Date signed **12-31-47**

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.....

Carl J. Glenn....., Registered Apprentice No. *57*,
working under my personal supervision.

Signed..... *Orrell E. Leckleley*.....

Licensed Embalmer No. *3544*.....

P. O. Address..... *St James 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..