

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3962**

FILED MAR 15 1948

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **296**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 yr. 6 mo 15 days**
(Specify whether
In this community **9 yr 6 mo 15 days**
years, months or days)

3. (a) PRINT FULL NAME **Pauline Ruth 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 **single**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **September 21 - 1895**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 5 19 hr. min.

9. Birthplace **Atherton Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housework**

11. Industry or business

12. Name **William L. Adams**
13. Birthplace **Atherton Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Fannie Dampier**
15. Birthplace **unknown Ky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Joe Harbin**
(b) Address **Independence Mo RFD #4**

17. (a) **Burial** (b) Date thereof **Mar 13, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Woodlawn Indep. Mo**

18. (a) Signature of funeral director **W. H. Mitchell**
(b) Address **Indep. Mo**

19. (a) **3-11-48** (b) **E. L. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Jackson City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3803 Pennsylvania 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 **March** day **10**
year **1948** hour **10** minute **15 P. M.**

21. I hereby certify that I attended the deceased from **Jan 1**, 1948, to **March 10**, 1948;
that I last saw her alive on **March 10**, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Tuberculosis**

Due to **Dementia Praecox**

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

23. Signature **Forrest Thomas** (M. D. number)
Address **St. Joseph, Mo** Date signed **3/11/48**

(Licensed Embalmer's Statement on Reverse Side) **State Hospital No 2**

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

MOTHER FATHER

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.....

working under my personal supervision.

Registered Apprentice No.....

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.