

FEDERAL SECURITY AGENCY
National Office of Vital StatisticsMISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **30241**Registration District No. **171**Primary Registration District No. **5637**Registrar's No. **4**

1. PLACE OF DEATH:

(a) County **Lafayette**
(b) City or town **Rural- Clay Twns.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lafayette Co. Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Weeks**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT
FULL NAME**Nancy Adams**3. (b) If veteran,
name war _____

3. (c) Social Security No. _____

4. Sex **Fe** / 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widow**
6. (b) Name of husband or wife **E. S. P. Adams**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 7, 1864-1864**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 5 22 hr. min.

9. Birthplace **Missouri** Mo. **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **Givens Masterson**
13. Birthplace **Missouri** Mo. **0**
(City, town, or county) (State or foreign country)
14. Maiden name **Grace E. Campbell**
15. Birthplace **Missouri** Mo. **0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lena Adams**
(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 31, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Campbell Cem. Odessa, Mo.**
Husman-Sparks

18. (a) Signature of funeral director _____
(b) Address **Odessa, Mo.**

19. (a) **Sept 2-1948** (b) **Letter Dr. Dr. Dr.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette**
(c) City or town **Odessa**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **29**
year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **July 1948** to **Aug 29 1948**
that I last saw h. **u** alive on **Aug 29**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardio renal disease**
Duration **years**

Due to _____

Due to **Item #7 corr. by aff. from fun. home -**
7-18-79. Verf. by fun. home record

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

Major findings:

Of operations _____
Of autopsy **1310**
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **W. K. Kappert** (M. D. or other) **MA**
Address **Wigginsville, Mo** Date signed **8/31/48**

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

OCT 1 1948

9-30-48

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

Henry L. Hunsicker

Licensed Embalmer No.

754

P. O. Address

Adm. Bldg.

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.

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 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **4 Weeks**
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT
FULL NAME**Nancy Adams**3. (b) If veteran,
name war _____

3. (c) Social Security No. _____

4. Sex **Fe /** 5. Color or race **W**
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 divorced **Widow**
 6. (b) Name of husband or wife **E. S. P. Adams**
 6. (c) Age of husband or wife if
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 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 5 22 hr. _____ min.

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

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER
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 13. Birthplace **Missouri** **Mo.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Grace E. Campbell**
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 (b) Address **Odessa, Mo.**

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 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Campbell Cem. Odessa, Mo.**

18. (a) Signature of funeral director **Husman-Sparks**
 (b) Address **Odessa, Mo.**

19. (a) **Sept 24, 1948** (b) **Letta Drummond**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Lafayette**
 (c) City or town **Odessa**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
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PHYSICIAN

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 (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 **W. H. Kappert** (M. D. or other) **MD**
 Address **Wigginville, Mo** Date signed **8/31/48**

