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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 1 1948

Registration District No. 7

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 30797
Registrar's No. 8307

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: CITY INFIRMARY
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 Yrs. 6 Mo. (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 007
(c) City or town St. Louis 4
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsneal
(If rural, give location)
(e) Citizen of foreign country? 13 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ARTHUR ADAMS
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex male 2
5. Color or race col.
6. (a) Single, widowed, married, divorced widower 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 31, 1889 (Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 15 If less than one day hr. min.

9. Birthplace S. Car. (City, town, or county) (State or foreign country)
10. Usual occupation nil
11. Industry or business
FATHER
12. Name James Adams
13. Birthplace S. Car. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Anna Garrett
15. Birthplace S. Car. (City, town, or county) (State or foreign country)
16. (a) Informant City Infirmary Record
(b) Address 5800 Arsenal St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-48 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cem
18. (a) Signature of funeral director A S Harrison
(b) Address 2906 Kenton Blvd
19. (a) SEP 22 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16 year 1948 hour 7:40 A.M. minute M.

21. I hereby certify that I attended the deceased from July 2, 1945, to September 16, 1948; that I last saw him alive on September 16, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
Suppurative Emaciation, advanced
Due to Determined by autopsy
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy as above

Duration

PHYSICIAN
Underline the cause of which death should be charged statistically.

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

23. Signature Palmer Prosser Bowdish (M. D. ~~or other~~)
Address 5800 Arsehal St. Date signed 9-20-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Ralph W Henson

Licensed Embalmer No. 9971

P. O. Address St. Louis, 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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 0 ct

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8307

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Arthur Adams

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased July (Month) 31 (Day) 88 (Year)

8. AGE: Years 59 Months 1 Days 12 If less than one day hr. min.

9. Birthplace (City, town, or county) S Car (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

OCT 18 1948

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 26
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-30797