

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1948
188

Registration District No. 188

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4292

State File No. 33449

Registrar's No. 74

1. PLACE OF DEATH:

(a) County LINCOLN
(b) City or town WINFIELD
(If outside city or town limits, write "RURAL" and name of 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 _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME JAMES ALBERT ADMIRE

3. (b) If veteran, name war No 3. (c) Social Security No. —

4. Sex male 5. Color or race W. 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife RUTH ANN ADMIRE 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased JAN 9 1861
(Month) (Day) (Year)

8. AGE: Years 87 Months 9 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace WINFIELD MO.
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

MOTHER-FATHER { 12. Name BEN F. ADMIRE
13. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)
14. Maiden name MARGARET ELSTON
15. Birthplace KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant WIFE
(b) Address WINFIELD

17. (a) BURIAL (b) Date thereof 10-26-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STAR HOPE SEM.

18. (a) Signature of funeral director Star Hope Sem.
(b) Address ELSBERRY, MO.

19. (a) 10-26-48 (b) J. C. Mearns
(Date received local registrar) (Registrar's signature) 11.2

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LINCOLN
(c) City or town WINFIELD
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 24
year 1948 hour 10 minute 20 AM.

21. I hereby certify that I attended the deceased from Aug 13
_____, 1948, to _____, 19____
that I last saw him alive on OCT. 23, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute cardiovascular disease
Duration 3 weeks

Due to Hypertension before Aug 13
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 930
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) (d) Means of injury _____
23. Signature D. H. Kelly (M. D. or other) D.O.
Address 909 E. 1st St. Mo. Date signed 10-26-48

11-1-1912

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.....

Charles R. [Signature]

Licensed Embalmer No.....

4012

P. O. Address.....

Elsberry, 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, above space should be left blank.