

FILED NOV 16 1948

Registration District No. **12**

Primary Registration District No. **1000**

Registrar's No. **1195**

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 #2
(If not in hospital or institution, write street number and town)

(d) Length of stay: In hospital or institution 4 mo 10 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll

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

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country NONE

3. (a) PRINT FULL NAME Clarence P. Adams

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day Seventh
year 1948 hour SIX minute 40 A.M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Elna Williford

6. (c) Age of husband or wife if alive 18 years

7. Birth date of deceased: October 9 1883
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 27 1948 to November 7 1948; that I last saw him alive on November 7 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>0</u>	<u>28</u>	hr. min.

Due to _____

Due to _____

9. Birthplace HALE MISSOURI
(City, town, or county) (State or foreign country)

Other conditions Generalized Atherosclerosis 5 yrs
(Include pregnancy within 3 months of death)

10. Usual occupation Farming

11. Industry or business Agriculture

12. Name John Q Adams

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Maest Hayes

15. Birthplace Illinois
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: M.I.

Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Robert Cecil Adams

(b) Address Chillicothe Mo.

17. (a) Burial (b) Date thereof 11-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hale Mo

18. (a) Signature of funeral director Frank E. Sista

(b) Address Hale Mo

19. (a) 11-8-48 (b) E. B. Jenkins
(Date received local registrar) (Registrar's signature)

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? 0

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature E. B. Jenkins (M. D. MD)
Address State Hospital #2 St. Joseph Mo Date signed 11/7/48

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

MOTHER FATHER

OCT 14 1954

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 *Frank E. Slater*

Licensed Embalmer No. *937*

P. O. Address. *Wale Md*

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.