

FILED NOV 2 1949

STANDARD CERTIFICATE OF DEATH

State File No. **33291**BIRTH NO. _____ REG. DIST. NO. 67 PRIMARY REG. DIST. NO. 5261 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY Christian			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Christian		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Seneca		c. LENGTH OF STAY (in this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Seneca		220
d. FULL NAME OF HOSPITAL OR INSTITUTION Garrison, Mo. Route			d. STREET ADDRESS (If rural, give location) Garrison, Mo. Route		
3. NAME OF DECEASED (Type or Print) a. (First) Martha		b. (Middle) Oliva	c. (Last) Adams	4. DATE OF DEATH (Month) (Day) (Year) 9 15 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 11-17-1873	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Leonard Walker		13b. MOTHER'S MAIDEN NAME Sarah James	14. NAME OF HUSBAND OR WIFE Newt Adams		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mable Gott ADDRESS Chadwick, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 8 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				4222
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Bronchitis				4 yrs
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:30 P. m. , from the causes and on the date stated above.					
23a. SIGNATURE M. C. Gentry (Degree or title) M.D.		23b. ADDRESS Adams Mo		23c. DATE SIGNED 9-21-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-18-1949	24c. NAME OF CEMETERY OR CREMATORY Garrison Cemetery	24d. LOCATION (City, town, or county) (State) Garrison Mo.		
DATE REC'D BY LOCAL REG. Dec 2 49	REGISTRAR'S SIGNATURE Lillie Barr		58 25. FUNERAL DIRECTOR'S SIGNATURE John Dean Harris ADDRESS Clever, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 27 1949

District Health Office No. 5

District File Number 1049-1161

Date Filed 10-31-49

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

John Alan Harris

Licensed Embalmer No. 4390

P. O. Address Cleaver, 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.