

No. 2
13 42

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

FILED MAR 13 1942

Registration District No. 318

Primary Registration District No. 2001

State File No.

Registrar's No. 132

1. PLACE OF DEATH:

(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 828 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community.
years, months or days)

3. (a) PRINT FULL NAME Sarah Adams

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Henry Adams 6. (c) Age of husband or wife if deceased Deceased years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 80 Unknown hr. min.

9. Birthplace Unknown Texas
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Thelma Morrow
(b) Address 828 Washington

17. (a) Burial (b) Date thereof 2-19-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Comfort Cem.

18. (a) Signature of funeral director W. P. Campbell

(b) Address 805 Washington

19. (a) 2-17-42 (b) S. W. Hendley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 828 Washington Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16th
year 1942 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from January 14th, 1942, to Feb. 16, 1942
that I last saw him alive on Feb. 13, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Instantaneous
Due to Hypertensive Heart Disease P
Arterio Sclerosis P

Due to
Other conditions 2nd Degree Burn of foot 5.6 wks.
(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?

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

23. Signature R. L. Jenkins (M. D. or other) M.O.
Address 305 1/2 College St. Date signed 2-17-42

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.....

W. P. Campbell....., Registered Apprentice No.
working under my personal supervision.

Signed

W. P. Campbell
Licensed Embalmer No. 1747

P. O. Address

Springfield
X

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **6634**

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Springfield**
(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

3. (a) PRINT FULL NAME

Sarah Adams

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex

F

5. Color or race

B

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

W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

80

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

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)

(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month

Day

Year

year **1942**

hour

minute

6:30 P.M.

21. I hereby certify that I attended the deceased from

Month

Day

Year

that I last saw him alive on **Sept 2-14-** 19**41**
and that death occurred on the date and hour stated above.
Immediate cause of death

Myocardial Infarction
and degenerative heart disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

and degenerative heart disease

Major findings:

Of operations

Of autopsy

Duration

of illness

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(c) Means of injury

23. Signature

(M. D. or other)

Address

Date signed

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

SUPPLEMENTARY

DR. R. E. JENKINS

PHYSICIAN AND SURGEON

OFFICE 305 1/2 COLLEGE ST.

RESIDENCE 810 N. WEAVER

RES. PHONE 3-6481 OFFICE PHONE 1596

SPRINGFIELD, MISSOURI

4-6-42

Dr. James B. Steward

Special Agent, Board of the Census

Jefferson City, Mo.

Dear Sir:

In Regards to causative factor of death of Sarah Adams

2-16-42 concerning which you sent a supplementary death certificate to me. I do not feel that minor burn on foot accidentally sustained 5-6 wks prior to death was a precipitating factor, rather the sudden death due primarily to Cardio- Vascular affair, in a patient of 80 years of age.

Yours Truly,

R. E. Jenkins M.D.
R. E. Jenkins M.D.