

REC'D DEC 13 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

38671
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township 1 Primary Registration District No. 100 Registered No. 1181
(c) City St. Joseph (d) Street No. 1522 Julie St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 10 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 352 Cora Alma Adams

(a) Residence, No. 1522 Julie St. Joseph St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF C. R. Adams
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) September 20, 1894
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 2 5
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Griswold, Iowa

FATHER 13. NAME Isaac T. Drayer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Iowa

MOTHER 15. MAIDEN NAME Sarah Ronk
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Iowa

17. INFORMANT C. R. Adams,
(ADDRESS) 1522 Julie, St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Auburn DATE Nov 28 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walter Meierhofer
1302 Faraon, St. Joseph, Mo

20. FILED Nov 28 38 H. J. Fogle
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 25, 1938

22. I HEREBY CERTIFY That I attended deceased from November 23, 38 to November 25, 38
I last saw her alive on November 25, 38 Death is said to have occurred on the date stated above, at 11:55a.m.
The principal cause of death and related causes of importance were as follows:

Acute Myo Carditis 11/23/38
Cardiac Asthenia
and Chronic Nephritis
No toxic explanation seen 8/6/38

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____ (Signed) Dr. John Messier M. D.
(Address) 109 1/2 N. 8th, St. Joseph, Mo.

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.

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,

Wilbur Kelly

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

W. H. Kelly
.....
Licensed Embalmer No. **Mo. 3946**

P. O. Address **St. Joseph, Missouri.**

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85-
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 1181
(c) City St Joseph (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Cora Alma Adams
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44 2 5
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Lawyer
9. Industry or business in which work was done, as saw mill, bank, etc. at home
10. Date deceased last worked at this occupation (month and year) Nov 1938
11. Total time (years) spent in this occupation about 20

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Nov 28 1938 AJ West Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 25 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
I last saw h _____ alive on _____, 19____ Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance: _____
Date of onset _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) John J. Steneck M. D.

(Address) 109 1/2 S 2nd St Joseph Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

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