

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.

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

24570  
Do not use this space.

AUG 7 1939

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1092  
 (c) City W.C. Mo. (d) Street No. General Hospital # 2 Registered No. 2783  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.  
 (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 Hattie Adams  
 (a) Residence, No. 1206 a K. 12th 2nd St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Coloured 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joe Adams  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-6-1889  
 7. AGE YEARS 50 MONTHS 5 DAYS 26 If LESS than 1 day, hrs. or min.  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none  
 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) Miss. 1  
 FATHER 13. NAME Unknown 9  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9  
 MOTHER 15. MAIDEN NAME Unknown  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 17. INFORMANT (ADDRESS) Record Clerk General Hosp  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Lawn DATE 7-12-39  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jarvis A. K. Jenkins 1212 Olive St.  
 20. FILED July 11, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-2 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 6-12 1939 to 7-2 1939  
 I last saw her alive on 7-2 1939 Death is said to have occurred on the date stated above, at 1:15 m. P.M.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis  
 Other contributory causes of importance: 23  
 Date of onset  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ 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?  
 If so, specify \_\_\_\_\_  
 (Signed) [Signature] M. D.  
 (Address) General Hospital # 2

**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 *Julius A. Fierbin*

Licensed Embalmer No. *2229*

P. O. Address *1212 Yvonne St*

**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.**