

DEPARTMENT OF COMMERCE MISSOURI STATE BOARD OF HEALTH  
BUREAU OF THE CENTRAL REGISTER  
STANDARD CERTIFICATE OF DEATH

State File No. 36298  
Registrar's No. 319

Registration District No. 398 Primary Registration District No. 5554

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: 9009 Wilson Road  
(d) Length of stay: In hospital or institution 4 years  
In this community 4 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 9009 Wilson Rd  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME: ISARC ADAMS  
(b) If veteran, name war none (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct - day 19 year 1939 hour \_\_\_\_\_ minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from June 1937 to Oct 1939; that I last saw him alive on Oct 18 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
(b) Name of husband or wife Frances Adams 6. (c) Age of husband or wife if alive 78 years  
7. Birth date of deceased March 31, 1861

Immediate cause of death Cerebral Hemorrhage Duration 10-16-39  
Demilitia

8. AGE: Years 78 Months 6 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Ch Myocarditis  
Ch Hypertension

9. Birthplace St. Joseph Mo.

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) ABC

10. Usual occupation Station Foreman

Major findings: Of operations \_\_\_\_\_

11. Industry or business Durlington RR

Of autopsy \_\_\_\_\_

12. Name of father Samuel Adams

13. Birthplace No record

14. Maiden name No record

15. Birthplace No record

16. (a) Informant's own signature Mr. Frances Adams

17. (a) Burial (b) Date thereof 10-21-39

18. (a) Signature of funeral director George W. Carson

19. (a) 10-20-39 (b) S. D. Clark

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

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Years of injury \_\_\_\_\_

23. Signature George W. Carson (M. D. or other) \_\_\_\_\_  
Address 11037 Union Rd July Date signed 10-19-39

DR PARK (Licensed Embalmer's Statement on Reverse Side) NO

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

REV. 2-17-38  
1 X1951

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**