

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D JUL 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20650

Registrar's No. 2267

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: K.C.T.B. Hospt
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether
 In this community non-resident
years, months or days)

3. (a) PRINT FULL NAME Sam Adair 360

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Kate Adair 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased Feb. 22 - 1885
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 10 If less than one day
hr. min.

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

10. Usual occupation Laborer

11. Industry or business 1

MOTHER FATHER { 12. Name Cal Adair }

13. Birthplace Iowa
(City, town, or county) (State or foreign country)

14. Maiden name BURNS

15. Birthplace Louisiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thos Adair

(b) Address 1240 Harris, Indep.

17. (a) Burial (b) Date thereof June 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leon Cemetery Iowa

18. (a) Signature of funeral director Frank J. Stewart

(b) Address Leon Iowa

19. (a) June 3, 1940 (b) Registrar's signature M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Independence, Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. 27th Northern
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2nd
 year 1940 hour 4 minute 40 P.M.

21. I hereby certify that I attended the deceased from May 29
 1940, to June 2 1940,
 that I last saw him alive on June 2 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulm. T.B.C. of R.
 Due to T.B.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Bilateral T.B. Pulm. T.B.C. w/ Cavitation

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 1

23. Signature CC Hayer, M.D. (M. D. or other)
 Address Indep, Mo Date signed 6-2-40

Duration

Approx 2 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically

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 me
✓, Registered Apprentice No. _____, working under my personal supervision. ✓

Signed Frank S Stewart
Licensed Embalmer No. 3706
P. O. Address Leon Iowa

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20650

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 399

Primary Registration District No. 1009

Registrar's No. 2267

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
R.C. J.B. Hosp.
(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 Sam Adams

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased Feb-27 1883
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 10 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address 6/3/40 M. M. Brown

19. (a) _____ (b) _____
(Date received local registrar) (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) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

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 L. C. Brown (M. D. or other) _____

Address _____ Date signed _____

