. S. No. 2
M—1-4-41
ev. 5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9507

Registration District No. APR 15 1939

Primary Registration District No. 1002

Registrar's No. 916

18
3
8

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2611 Campbell St., K.C. Mo. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Treated by Gen. Hosp. Physicians since Nov. 1940 (Specify whether

In this community 35 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3 (If outside city or town limits, write "RURAL")

(d) Street No. 2611 Campbell Street 8 (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Ralph R. Adams

3. (b) If veteran, name war no.

3. (c) Social Security No. ~~496-07-8817~~ no

4. Sex Male

5. Color or race W

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

6. (b) Name of husband or wife Florence Olive Adams

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased Aug (Month) 23 (Day) 1877 (Year)

8. AGE: Years 63 Months 6 Days 11 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name George Adams
13. Birthplace (City, town, or county) Ky 1 (State or foreign country)

MOTHER
14. Maiden name No Record
15. Birthplace (City, town, or county) No Record 9 (State or foreign country)

16. (a) Informant Richard T Adams

(b) Address 2611 Campbell

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Mar-7-41 (Month) (Day) (Year)

(c) Place: burial or cremation Richland Mo

18. (a) Signature of funeral director Mrs. C. L. Foster

(b) Address 918 Brooklyn

19. (a) Mar 5-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4th year 1941 hour 7 minute 35 P M.

21. I hereby certify that I attended the deceased from 11-28-40, 19__ to 3-4-41, 19__; that I last saw him alive on 3-4-41, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death CARCINOMA OF LARYNX

Due to ~~11~~ 10

Due to 47a

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Emery R. Thorn (M.D. or other)

Address Med. Director K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Dwight C. Browning

Licensed Embalmer No. 2724

P. O. Address K.C. mo

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.