

13-46  
17-39  
X271

State File No. \_\_\_\_\_

FILED DEC 11 1941  
Registration District No. 237

Primary Registration District No. 4508

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Bloomfield, Tenn  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard <sup>103</sup>  
(c) City or town Bloomfield <sup>0</sup>  
(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.? 0 years.

3. (a) PRINT FULL NAME FRANKLIN PAUL ADAMS

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife -- 6. (c) Age of husband or wife if alive -- years

7. Birth date of deceased 10--- 13--- 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
--- --- 8 hr. min.

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

10. Usual occupation ---

11. Industry or business ---

12. Name Paul Adams

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

14. Maiden name Rizzio Hobey

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

16. (a) Informant Paul Adams

(b) Address Bloomfield, Mo.

17. (a) Burial (b) Date thereof 10-22-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walker cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 21st  
year 1941 hour 1:30 minute P. M.

21. I hereby certify that I attended the deceased from Oct. 13 1941 to Oct. 13 1941  
that I last saw him alive on Oct. 13 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth  
6 months gestation

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: 159  
Of operations \_\_\_\_\_

Of autopsy ---

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 S.S. Heaver (M. D. or other)

Address Wester Date signed 10/24/41

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

1030

RECEIVED

HS 10

12-15-68

8222X

District Health Office No. 2,

District File Number 1241-1668

Date Filed 12/10/41

LOCAL RECORD

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 Infant was not embalmed.

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39668

Registration District No. 837 Primary Registration District No. 9508 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Stoddard
- (b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution: \_\_\_\_\_  
(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

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Franklin J. Adam

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 \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_  
years

7. Birth date of deceased Oct 13  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
(If less than one day \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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 Walton Cem -

18. (a) Signature of funeral director Walter H. Smith Co.

(b) Address Blossfield Mrs

19. (a) 11-4-41 (b) Walter H. Smith  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

