

FILED APR 8 1945

Registration District No. **1945**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution: **St Marys Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 months**
(Specify whether)

In this community **6 yrs**
years, months or days

3. (a) PRINT FULL NAME **Alonzo E Adams**

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

3. (c) Social Security No. **702-18-5916**

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

6. (b) Name of husband or wife **Ethel G. Adams**

6. (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **Aug 29 1878**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	46	27	hr. min.

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

10. Usual occupation **Switchman**

11. Industry or business **Mo Pac Ry**

12. Name **James W Adams**

13. Birthplace **Ill 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Mattie Crocker**

15. Birthplace **Ill 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ethel G Adams**

(b) Address **Ind. Mo. Rant # 2**

17. (a) Place of burial or cremation **Cremation**

(b) Date thereof **Mar 29 1945**
(Month) (Day) (Year)

(c) Place: burial or cremation **Edinwood Cem**

18. (a) Signature of funeral director **Mr. C. H. Foster**

(b) Address **918 Broadway N.E. 4th**

19. (a) Date received local registrar **3-28-45**

(b) Registrar's signature **M. M. Brown**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Independence Mo**
(If outside city or town limits, write "RURAL")

(d) Street No. **Route NO-2.**
(If rural, give location)

(e) Citizen of foreign country? **No**
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **26**
year **1943** hour **10** minute **15** A. M.

21. I hereby certify that I attended the deceased from **Jan. 3 1943** to **March 26 1943**
that I last saw him alive on **March 25 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary atherosclerosis with peritonitis**

Due to: **Coronary atherosclerosis**

Due to: **Heart failure**

Other conditions: **(Include pregnancy within 3 months of death)**

Major findings: **Of operations:**

Of autopsy: **See cause of death**

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 **H. C. Coakley D.** (M. D.)

Address **1002 N. 1st St. Bldg** **Date signed** **Mar 27 45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

361

101 - (111) 1000000
Mar 50 3 7
Angeles, Betty

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, fact should be so stated above.