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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 1 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 133

Primary Registration District No. 3022

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Harrison Co. Mo.  
 (b) City or town Bethany Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution all his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 1  
 (c) City or town 1  
 (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 Leroy Adams  
 3. (b) If veteran, name war. - 3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7  
 year 1943 hour 9 minute 15 P.M.  
 21. I hereby certify that I attended the deceased from Oct 20, 1942 to May 5, 1943  
 that I last saw him alive on May 30, 1943  
 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or Race White 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Kathaline Adams 6. (c) Age of husband or wife if alive 30 years  
 7. Birth date of deceased 1-21-1886  
 (Month) (Day) (Year)

Immediate cause of death Carcinoma of Liver  
 Duration

8. AGE: Years Months Days If less than one day  
57 3 16 hr. .... min.

Due to .....  
 Due to .....  
 Other conditions (Include pregnancy within 3 months of death) H-6 f

MOTHER FATHER

9. Birthplace Harrison Co. Mo. Mo. O  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer  
 11. Industry or business Retired  
 12. Name Wm. O. Adams  
 13. Birthplace Illinois  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Laure J. Wilking  
 15. Birthplace Harrison Co. Mo. O  
 (City, town, or county) (State or foreign country)  
 16. (a) Informant Kathaline Adams  
 (b) Address Beth 212 Mo.  
 17. (a) Burial (b) Date thereof May 9 1943  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Burial  
 18. (a) Signature of funeral director S. Michael  
 (b) Address Bethany  
 19. (a) May 15 '43 (b) Zola M. Burres  
 (Date received local registrar) (Registrar's signature)

Major findings: Of operations .....  
 Of autopsy Carcinoma of Liver  
Liver extremely large, spleen enlarged  
 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 Ralph L. Walker (M.D. or other) D.O.  
 Address Bethany, Mo Date signed 5/9/43

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

*S. W. Haas*

Licensed Embalmer No.....

*1078*

P. O. Address.....

*Butte*

**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. June  
Registrar's No. 0-0

Registration District No. 133

Primary Registration District No. 3022

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

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Bethany  
(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

3. (a) PRINT FULL NAME Leroy 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 m

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

7. Birth date of deceased Jan 2, 1902  
(Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 2 If less than one day \_\_\_\_\_ min.

9. Birthplace Harrison Mo.  
(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 \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison

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

(d) Street No. no st. address  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him/her 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)

PHYSICIAN

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

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

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?  
\_\_\_\_\_ (Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

S-17955