

No. 2  
11-10-39  
17-39  
1 X2148

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9336

ED NOV 18 1943

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Out Grove Rural  
(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 \_\_\_\_\_  
In this community 18 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Out Grove  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural R. #1  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Abraham Lincoln Adams

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

4. Sex M 5. Color or Race Wh 6. (a) Single, widowed, married, divorced M 1

6. (b) Name of husband or wife Mrs Anna Elizabeth Adams 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased Dec - 25 1864  
(Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 12 If less than one day hr. min.

9. Birthplace Sagamore Co. Ill. 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad worker

11. Industry or business RR co.

12. Name Clayborn Adams

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

14. Maiden name Matilda Barwick

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

16. (a) Informant Robert Adams

(b) Address Brain Valley Mo

17. (a) Burial (b) Date thereof 11-9-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Cem.

18. (a) Signature of funeral director W. M. Koppert

(b) Address Buckner Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov - day 7  
year 1943 hour 6: minute 00 P. M.

21. I hereby certify that I attended the deceased from about 2 weeks  
Oct 24 1943, to Nov 5 1943  
that I last saw him alive on Nov 5 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Impairment of old age with heart complications

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 162 lb

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 John R Crawford (M. D. or other) \_\_\_\_\_  
Address Brain Valley Mo Date signed 11-8-43

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

MOTHER FATHER



Registration District No. 10-2

Primary Registration District No. 55-73A

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

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Rural SNI-A-BAY  
 (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) 18 yr.

3. (a) PRINT FULL NAME Abraham L. 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 Annie Elizabeth 6. (c) Age of husband or wife if alive 11 years

7. Birth date of deceased Dec. 25 - 1892  
 (Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Railroad worker

11. Industry or business \_\_\_\_\_

12. Name Wayborn - Adams

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

14. Maiden name Matilda Barrecks  
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Graham Adams  
 (b) Address Grain Valley - Mo.

17. (a) Burial (b) Date thereof 11-9-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Cem.  
 18. (a) Signature of funeral director V. M. Rappert  
 (b) Address Buckner, Mo.

19. (a) Dec 24 43 (b) Mrs. Jessie M. Weston  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Oak Grove  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. R. R. 1  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Year 1943 Day \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Immediate cause of death Inferiorities of heart complications

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

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

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

Major findings: 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 John P. Crawford (M. D. or other) \_\_\_\_\_  
 Address Grain Valley, Mo. Date signed 11-8-43

Supplementary

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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