

No. 2
M-2-43
5-17-39
PT X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38363

State File No. _____

FILED NOV 15 1943
Registration District No. 4515

Primary Registration District No. 5574

Registrar's No. 7

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Van Buren Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3 mi N.E. of Cooperell
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 3 mo
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 3 mi N.E. of Cooperell
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Noah F Adams
 3. (b) If veteran, name war No 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month NOV day 10th
 year 1943 hour 6 minute 15 P.M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married. 2 divorced Widowed
 6. (b) Name of husband or wife Louisa Adams 6. (c) Age of husband or wife if alive 5 years
 7. Birth date of deceased Sept 2-1865
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-6-1941 to 11-10-1943
 that I last saw him alive on 11-10-1943
 and that death occurred on the date and hour stated above.

8. AGE: 78 Years 2 Months 8 Days - If less than one day -
 hr. _____ min.

Immediate cause of death
Cerebral thrombosis
Chronic Endocarditis
 Duration 1 day
20 1/2 hrs

9. Birthplace Lafayette Co. Mo
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired Farmer

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

MOTHER FATHER
 11. Industry or business _____
 12. Name Jacob Adams
 13. Birthplace Mo
(City, town, or county) (State or foreign country)
 14. Maiden name Margaret J. Frazier
 15. Birthplace Mo
(City, town, or county) (State or foreign country)

Major findings: _____
 Of operations _____
 Of autopsy _____
 PHYSICIAN g J. H.
 Underline the cause to which death should be charged statistically.

16. (a) Informant Robert M. Adams
 (b) Address Brain Valley Mo
 17. (a) Burial (b) Date thereof 11-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Adams Cem. near Cooperell
 18. (a) Signature of funeral director N. D. Langford
 (b) Address Leas Summit Mo
 19. (a) Nov. 13 1943 (b) Mrs. Clifford Hunt
(Date received local registrar) (Registrar's signature)

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) (c) Means of Injury _____
 23. Signature [Signature] (M. D. or other) 743
 Address Leas Summit Mo Date signed 11/24/43

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 W. B. Langford

Licensed Embalmer No. 3833

P. O. Address Lee's Summit, 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.