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4-41
7-39
X26390

State File No. _____

FILED JAN 27 1944

Primary Registration District No. 2000

Registrar's No. 6

1. PLACE OF DEATH: **GREENE**

(a) County **GREENE**

(b) City or town **SPRINGFIELD MO.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **ST. JOHN'S HOSPITAL**
(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 **CLARA PEARL ADAMS**

3. (b) If veteran, name war **NONE**

3. (c) Social Security No. **NONE**

4. Sex **FEMALE** / 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **TROY ADAMS**

6. (c) Age of husband or wife if alive **44** years **19** (Day) **1901** (Year)

7. Birth date of deceased **may 19 1901**
(Month) (Day) (Year)

8. AGE: Years **42** Months **7** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **GREENE CO. MO. U**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business **In home**

12. Name **Walter Sharp**

13. Birthplace **Columbus Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Josephine Hottel**
(City, town, or county) (State or foreign country)

15. Birthplace **Waukesha Wis**
(City, town, or county) (State or foreign country)

16. (a) Informant **Troy Adams**

(b) Address **Fair Grove Mo.**

17. (a) **Burial** (b) Date thereof **Jan 6, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt Comfort Mo.**

18. (a) Signature of funeral director **J. W. Klingner**

(b) Address **Springfield Mo.**

19. (a) **1-6-44** (b) **J. W. Klingner**
(Date received local registrar) (Registrar's signature)

984 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE** **39**

(c) City or town **FAIR GROVE** **0**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) **1**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JAN** day **2nd**
year **1944** hour **9** minute **10 P.** M.

21. I hereby certify that I attended the deceased from **Jan 2nd** to **Jan 3rd** 19**44**
at **FAIR GROVE MO.** and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia** Duration **48 hrs.**

Due to **Pregnancy**

Due to **149 lb**

Other conditions **149 lb**
(Include pregnancy within 3 months of death)

Major findings: **Cerebral Apoplexy with delivery of living child**

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? **Yes** (Specify type of place) **Means of injury** **MO**

23. Signature **Max J. [unclear]** (M. D. or other) **MO**

Address **Springfield Mo** Date signed **1-4-44**

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

JAN 26 1944

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.....

Roy A. Savin

Licensed Embalmer No. *1763*

P. O. Address *Springfield 9*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

X