

FILED MAY 15 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

15574
Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 294
(b) Township Franklin Primary Registration District No. 4439 Registered No. 105
(c) City Clark (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Sumner J. Addison
(a) Residence, No. _____ St. 7
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF John Henry Addison

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
81 9 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lee

FATHER 13. NAME John Ridinger

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME Pauline Nell

15. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Mrs. Walter Smith, Clark, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Appelhaus Chapel DATE Apr 17 1944

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fred Thompson, Mulvany, Mo

20. FILED 8-8-44 1944 Erma Kavel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 15 1944

22. I HEREBY CERTIFY, That I attended deceased from Aug 6 1941 to Apr. 13 1944
I last saw de alive on Apr. 13 1944. Death is said to have occurred on the date stated above, at 3a. m.
The principal cause of death and related causes of importance were as follows:

John Pneumonia of left lungs

Other contributory causes of importance:

Fracture of left hip

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 1944
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Dr. J. H. Tomlinson, M.D.
(Address) Surgeon, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 10

District File Number 5-44-1016

Date Filed MAY 12 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

Miss Irene Thompson

Licensed Embalmer No.

3282

P. O. Address

Madison, Wis

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

If this body is not embalmed, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15574

Registration District No. 294

Primary Registration District No. 4409

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Clark
(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 Lurenda J. Adkisson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F **5. Color or race** W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ (years)

7. Birth date of deceased July 13 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 9 Days _____ (less than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

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** _____ (Month) (Day) (Year)
(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 _____ (b) County _____

(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour _____ 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 _____

Due to Infer pneumonia, both lungs

Due to Fracture of hip

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) Accident

(b) Date of occurrence March 16, 1944

(c) Where did injury occur? Clark, Randolph Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? no (Specify type of place)

(e) Means of injury Fell in Room

23. Signature D. J. Tompkins (M. D. or other) D.O.

Address Sturgeon, Mo **Date signed** 5/23/44

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

paid by exchange

100.

152 9 H. Jones