

S. No. 2
M-5-43
5-17-39
I X36871

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

29070
8465
State File No.
Registrar's No.

FILED OCT 13 1944 18
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 4 weeks
In this community 6 months (Specify whether years, months or days)

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

4. Sex Female 5. Color or race Col
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife S. B. Adams
6. (c) Age of husband or wife if alive Unk years
7. Birth date of deceased January 26, 1898
(Month) (Day) (Year)

8. AGE: Years 46 Months 8 Days 5
If less than one day hr. min.

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

10. Usual occupation Inspector

11. Industry or business Arsenal Plant

12. Name Andrew Fields

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

14. Maiden name Johanna Clark

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

16. (a) Informant George W. Fields

(b) Address 1844 O Fallon Street

17. (a) Removed Date thereof 10-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Disposal

18. (a) Signature of funeral director J. F. Brudick

(b) Address 3517

19. (a) OCT 4 1944 (Date received local registrar)
J. F. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0-1
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 21
(d) Street No. 1844 O Fallon Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1,
year 1944 hour 11 minute 35 P. M.
21. I hereby certify that I attended the deceased from August
21, 1944, to October 1, 1944
that I last saw her alive on October 1, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Atrophic Superficial gastritis
Duration Unk

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 A. M. Hutchell (M.D. or other)
Address 2301 W. Hutchell Date signed 10/3/44

Duration
Unk
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

P. M. Green

Licensed Embalmer No.....

1173

P. O. Address.....

5517 Dacade ave

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.