

U. S. No. 2  
DOM-5-43  
Rev. 5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24205

**FILED** AUG 13 1945

Registration District No. 135

Primary Registration District No. 5579

Registrar's No. 25

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Waverly  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Jasper Co TB Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Albert Preston Adams

3. (b) If veteran, name war No

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 20 1891  
(Month) (Day) (Year)

8. AGE: Years 54 Months 1 Days 4

If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

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

12. Name W. P. Adams

13. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

14. Maiden name Ethel Richardson

15. Birthplace Missouri 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Acquaintance

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof July 28 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cem

18. (a) Signature of funeral director Walter A. [unclear]

(b) Address Waverly, Mo

19. (a) July 23 1945 (b) Mrs. Millie Logg  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49

(c) City or town Waverly 6  
(If outside city or town limits, write "RURAL")

(d) Street No. 601 So Hall 2  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22  
year 1945 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from July 15, 1945 to July 22, 1945; that I last saw him alive on July 22, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Pulmonary Tuberculosis

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 131

(1) 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)

(a) Means of injury \_\_\_\_\_

23. Signature Gene E. Douglas (M. D. or other) 0

Address Waverly, Mo Date signed 7/24/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

1183

45-7-618

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 myself

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 4304

P. O. Address Webb City 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.