

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED NOV 23 1945
318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **9299**

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
5712 CABANNE AVE
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____

(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")

(d) Street No. **5712 CABANNE AVE**
(If rural, give location)

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

3. (a) PRINT FULL NAME **GEORGE WILBUR ADAMS**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **KATHRINE** 6. (c) Age of husband or wife if alive **79** years

7. Birth date of deceased **APRIL 4 1866**
(Month) (Day) (Year)

8. AGE: Years **79** Months **7** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace **OHIO** (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation **SALESMAN (RETIRED)**

11. Industry or business **FRED CROSS SHOE CO**

MOTHER FATHER

12. Name **JAMES M. ADAMS**

13. Birthplace **DELAWARE** (City, town, or county) _____ (State or foreign country) _____

14. Maiden name **MARY CANNON**

15. Birthplace **DELAWARE** (City, town, or county) _____ (State or foreign country) _____

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

(b) Address **728 Yale Ave**

17. (a) **BURIAL** (Burial, cremation, or removal) (b) Date thereof **11/15/45**
(Month) (Day) (Year)

(c) Place: burial or cremation **W. HILL CEM.**

18. (a) Signature of funeral director **J. J. Bredek**

(b) Address **5165 Delmar St.**

19. (a) **NOV 15 1945** (Date received) (b) **J. J. Bredek** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOV**, day **14**, year **1945** hour **12:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **May 4, 1945** to **Nov 14, 1945** that I last saw ~~her~~ **him** alive on **Nov 13, 1945** and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocardial Infarction** 1 day
Ch. Pulmonary Hypertension 1 yr
Due to **arterio-sclerosis** 10 yrs
Due to **Hypertension** 10 yrs

Other conditions **Arteriosclerosis** 10 yrs
(Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy **131**

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. J. Bredek** (M. D. or other) **MD**
Address **4957 Maryland** Date signed **11/14/45**

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

H. G. Jarvis

Licensed Embalmer No.

3384

P. O. Address

H. Jarvis

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.