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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 25 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8219**
Registrar's No. **173**

Registration District No. **55** Primary Registration District No. **3011**

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

1. PLACE OF DEATH:

(a) County **Carroll**

(b) City or town **Carrollton**
(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 years, months or days) **All Life**

3. (a) PRINT FULL NAME **Earl Edward Adkins**

3. (b) If veteran, name war **No**

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

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **None**

6. (b) Name of husband or wife **None**

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

7. Birth date of deceased **February 15 1947**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
--	--	--	2 hr. 30 min.

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

10. Usual occupation **None**

11. Industry or business **None**

12. Name **Hugh B. Adkins**

13. Birthplace **Winthrop Arkansas**
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Earnest**

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

16. (a) Informant **Hugh B. Adkins**

(b) Address **103 E. Boston Carrollton**

17. (a) Burial **Burial** **(b) Date thereof** **Feb. 15, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Adkins Cemetery**

18. (a) Signature of funeral director **Marshall Fun. Ho.**

(b) Address **Carrollton, Mo.**

19. (a) 2/15/47 **(b) Mrs. Neberd Caldwell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carroll**

(c) City or town **Carrollton**
(If outside city or town limits, write "RURAL")

(d) Street No. **103 E. Boston**
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **15**
year **1947** hour **2** minute **15** P.M.

21. I hereby certify that I attended the deceased from **Feb. 15**
1947, to **Feb. 15**, **1947**;
that I last saw him alive on **Feb. 15**, **1947**,
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pneumonia

Due to _____
Lifting & work

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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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? _____

(Specify type of place)

While at work? _____ (c) Means of injury **0**

23. Signature **W. Hamilton, M.D.** (M. D. or other)

Address **Carrollton, Mo.** Date signed **2/15/47**

Duration **2 1/2 hrs.**

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-24-41

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 P. M. Marshall

Licensed Embalmer No. 2525

P. O. Address Carrollton, Missouri

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.