

FILED APR 2-1947

Registration District No. **77**Primary Registration District No. **3016**Registrar's No. **73**

1. PLACE OF DEATH:

(a) County **COLE**
 (b) City or town **JEFFERSON CITY, MO.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
426 CASE
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community **LIFE**
 years, months or days)

3. (a) PRINT

FULL NAME **ANNA HILDA ADAMS**

3. (b) If veteran,

3. (c) Social Security

name war **NO**

No.

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**6. (b) Name of husband or wife **CLYDE ADAMS** 6. (c) Age of husband or wife if alive **45** years7. Birth date of deceased **APRIL 2, 1905**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
41 **11** **18** hr. **0** min.9. Birthplace **MARYS HOME, MO.**
(City, town, or county) (State or foreign country)10. Usual occupation **TWEEDIE FOOTWEAR**

11. Industry or business _____

12. Name **ESSIC HOWARD**13. Birthplace **WARRENTON, MO.**
(City, town, or county) (State or foreign country)14. Maiden name **JOSEPHINE TARRIAN**15. Birthplace **MARTHASVILLE, MO.**
(City, town, or county) (State or foreign country)16. (a) Informant **CLYDE ADAMS**
(b) Address **JEFFERSON CITY, MO.**17. (a) **BURIAL** (b) Date thereof **3/24/47**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **RIVERVIEW CEMETERY**18. (a) Signature of funeral director **Sylvester Dull**(b) Address **JEFFERSON CITY, MO.**19. (a) **3-24-47** (b) **A. P. Harris MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **COLE**
 (c) City or town **JEFFERSON CITY, MO.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **426 CASE**
 (If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **20**
year **1947** hour **10 PM** minute **30** M.21. I hereby certify that I attended the deceased from **Mar 20**, 19**47**, to _____, 19**47**;
that I last saw **him** alive on **Mar 20**, 19**47**;
and that death occurred on the date and hour stated above.Immediate cause of death **Carcinoma** Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: **CHOLESTASIS**
Of operations **NO SIGNIFICANT**Of autopsy **TYPHOID**
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? _____

(Specify type of place) _____
(e) Means of injury _____23. Signature **Rein E Dailer MD** (M. D. or other) **MD**Address **Jefferson City MO** Date signed **3-22-47**

3/31/47

Director of Health Officer No. 91

RECEIVED

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

Melvin L. Janssens

Registered Apprentice No. *489*

working under my personal supervision.

Signed

Sylvester Dulle

Licensed Embalmer No. *4321*

P. O. Address *Jefferson City*

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.

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Jefferson city
(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)

3. (a) PRINT FULL NAME Anna H. Adams
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 m

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

7. Birth date of deceased: April 2 (Month) 1947 (Day) 1947 (Year)

8. AGE: Years 41 Months _____ Days _____ (If less than one day) hr. _____ min. _____

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country) Mo

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)
(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 _____

20. DATE OF DEATH: Month April 20
year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Duration _____
Due to Primary site gastric carcinoma
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
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 Heather A. Taylor (M. D. or other) MD
Address Jefferson City, MO Date signed _____

SUPPLEMENTAL

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

2B
45
43880

8342