

No. 2
-12-45
5-17-39
I X47070

FILED **MAY 19 1947**

2000

Registration District No. **128**

Primary Registration District No.

Registrar's No. **431**

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

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Burge Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 hrs. 15 min.**
(Specify whether
In this community **same**
years, months or days)

3. (a) PRINT MARCA BENNETTE ADAMS
FULL NAME

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

4. Sex **Female** / 5. Color or race **WHITE**
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 **May 10 1947**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
13 hr. 15 min.

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

10. Usual occupation **Infant**

11. Industry or business **--**

MOTHER FATHER
12. Name **Robin Adair Adams**
13. Birthplace **Deacon, New York**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Rebecca Hamilton**
15. Birthplace **Marshfield, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. David Hamilton**
(b) Address **641 East Lombard, Springfield**

17. (a) **Burial** (b) Date thereof **5/11/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Marshfield, Mo.**

18. (a) Signature of funeral director **H.H. Lohmeyer**
(b) Address **Springfield, Mo.**

19. (a) **5-11-47** (b) **H. H. Lohmeyer MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
(c) City or town **641 East Lombard Springfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **Springfield** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **10**
year **1947** hour **5** minute **30 P.** M.
21. I hereby certify that I attended the deceased from **May 10**
1947 to **May 10 1947**
that I last saw her alive on **May 10 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity** Duration **13 hrs. 15 min.**

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **159**
Of autopsy

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) _____
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 **Thomas S. Harris** (M. D. or other) **MD**
Address **Medical Arts Bldg.** Date signed **5/10/47**

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.....

This body was not embalmed.

Licensed Embalmer No.....

P. O. Address.....

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.