No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 12 1948

Registration District No. 164

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3032

State File No. 42133

Registrar's No. 140

1. PLACE OF DEATH:
(a) County: Johnson
(b) City or town: Warrensburg, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robbins Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 months (Specify whether years, months or days)
In this community: 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Johnson 57
(c) City or town: Knob Noster, Mo. (If outside city or town limits, write "RURAL.") 0
(d) Street No.: None (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country:

3. (a) PRINT FULL NAME: Mary Ann (May) Adcock

3. (b) If veteran, name war: no.

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: none.

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

7. Birth date of deceased: May (Month) 29 (Day) 1861 (Year)

8. AGE: Years 86 | Months 7 | Days 0 | If less than one day: hr. min. 0

9. Birthplace: Knob Noster (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Seamstress

11. Industry or business:

FATHER
12. Name: Mose F. Adcock
13. Birthplace: (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name: Mary T. Fugua
15. Birthplace: (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant: Mr. A. S. Adcock
(b) Address: Knob Noster, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/31/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Knob Noster Cemetery

18. (a) Signature of funeral director: Baker & Sauls.
(b) Address: Knob Noster, Missouri

19. (a) Jan. 3, 1948 (Date received local registrar) (b) Savannah Outterbridge (Registrar's signature) 1470

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 29 year: 1947 hour: 1 minute: 30 P.M.

21. I hereby certify that I attended the deceased from Dec 21, 1947 to Dec 29, 1947 and that I last saw her alive on Dec 21, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia, bronchial	2 days
Due to: H of fracture	4 months
Due to: Senility	5 years
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTAL INFORMATION REQUESTED

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) 57
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: J. Reed Dixon (M. D. or other)
Address: Warrensburg, Mo. Date signed: 1-3-48

(Licensed Embalmer's Statement on Reverse Side)

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 W. Raymond Barker, Registered Apprentice No. 25 working under my personal supervision.

Signed C. L. Sauls

Licensed Embalmer No. 1086

P. O. Address, Knob Noster, M

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.

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THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 140

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg
(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
In this community
years, months or days)

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

3. (a) PRINT FULL NAME Mary Ann Adcock

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased May 29 1947
(Month) (Day) (Year)

8. AGE: Years 86 Months 2 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day 29
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
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) accident

(b) Date of occurrence Sept. 10 1947 - Fell in room of her home

(c) Where did injury occur? Warrensburg (City or town) Johnson (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home (Specify type of place)
While at work? — (e) Means of injury Fractured rt. hip

23. Signature J Reed Maison MD (M. D. or other)
Address Warrensburg MO Date signed Jan 14 49

SUPPLEMENTARY

42133