

No. 2
-1/47
-17-39

FILED JAN 7 1948
Registration District No. **2258**

Primary Registration District No. **4896**

Registrar's No. **36**

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Wardell City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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 Missouri County Jackson

(c) City or town Wardell Mo Pine
(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 Samuel L. Adcock

3. (b) If veteran, name war.....

3. (c) Social Security No.

20. DATE OF DEATH: Month Jan day 11
year 1948 hour 12:30 minute 34 M.

21. I hereby certify that I attended the deceased from Jan 1, 1946
1947, to Dec 7, 1948
that I last saw him alive on Dec 7, 1948
and that death occurred on the date and hour stated above.

4. Sex M Color or race W

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

6. (b) Name of husband or wife Pella Adcock

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

7. Birth date of deceased..... (Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis 3 yr

8. AGE:	Years	Months	Days	If less than one day
<u>53</u>				br. min.

Due to.....

Due to.....

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

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

10. Usual occupation labor

11. Industry or business.....

12. Name George Adcock

13. Birthplace Middle Tenn (City, town, or county) (State or foreign country)

14. Maiden name Lillian Gibbs

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

Major findings: 3 13

Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause of which death should be charged statistically.

16. (a) Informant Tennie Tennant

(b) Address Wardell mo

17. (a) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation Partridgeville Gr

18. (a) Signature of funeral director Walter Tennant

(b) Address Partridgeville mo

19. (a) 12-1-1948 (Date received local registrar)

Mrs. H. Sullert (Registrar's signature)

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?..... (e) Means of injury 0

23. Signature H. Sullert (M. D. or other)

Address Wardell Date signed.....

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

MOTHER FATHER

1-48-4

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 Joseph A. DeLisle
Licensed Embalmer No. 488
P. O. Address Stageville Ga

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42546
Registrar's No. 36

Registration District No. _____ Primary Registration District No. 4396

1. PLACE OF DEATH:
(a) County Pemiscot
(b) City or town Wardell
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Samuel S Adcock
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
8. AGE: Years _____ Months _____ Days _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 12-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

13. (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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

Major findings:
Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed 12-12-47

SUPPLEMENTARY

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

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

