WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Barton

Township [illegible]

or

Village Murder Mines

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 42

Primary Registration District No. 4026

File No. 31929

Registered No. 14.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Anna Adamson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: May (Month) 30 (Day), 1838 (Year)

AGE: 74 yrs. 4 mos. 29 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —0—0

BIRTHPLACE (City or town, State or foreign country): England

PARENTS

NAME OF FATHER: Joseph Fletcher

BIRTHPLACE OF FATHER (City or town, State or foreign country): England

MAIDEN NAME OF MOTHER: Ann Gaill

BIRTHPLACE OF MOTHER (City or town, State or foreign country): England

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Adamson

(ADDRESS) Weir City Kansas

Filed 10/31, 1912. G J P Gish M D
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 29 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 28, 1912, to Oct 29, 1912, that I last saw her alive on Oct 29, 1912, and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

42A

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Hemorrhage Brain

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) G J P Gish M. D.

10/31, 1912 (Address) Murder Mines Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Pittsburg Ks

DATE OF BURIAL: Oct 31, 1912

UNDERTAKER: M. A. Gorrell

ADDRESS: Pittsburg Ks

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or*

Village _____ *or*

City _____ (NO. _____, _____ St.: _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ ; Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS