

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

1 PLACE OF DEATH

County Adair
Township Clay
or
Village
or
City (NO. St. Ward)

Registration District No. 1023 File No. 13685
Primary Registration District No. 5006 Registered No. 19

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

2 FULL NAME John Quincy Adams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)

16 DATE OF DEATH April 29, 1917
(Month) (Day) (Year)

6 DATE OF BIRTH Nov 30, 1872
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 13, 1917 to April 13, 1917 that I last saw him alive on April 13, 1917

7 AGE 44 yrs. 4 mos. 29 ds. If LESS than 1 day.....hrs. or.....min.?

and that death occurred, on the date stated above, at 4. a. m.

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry business, or establishment in which employed (or employer) Saint Stock

The CAUSE OF DEATH* was as follows:
Interstitial nephritis.
131
120
(Duration).....yrs. 3 mos. ds.

9 BIRTHPLACE (City or town, State or foreign country) Green City Mo

CONTRIBUTORY (Secondary) (Duration).....yrs. mos. ds.

10 NAME OF FATHER Joe. P. Adams

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

12 MAIDEN NAME OF MOTHER Mandy Wade

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

(Signed) M. F. Kennedy M. D. April 29, 1917 (Address) Kirkville Mo

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) E. S. Jameson (Address) Greentop Mo

18 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.....

15 Filed April 30, 1917 J. L. Church Registrar

19 PLACE OF BURIAL OR REMOVAL Bethel cemetery DATE OF BURIAL April 30, 1917

20 UNDERTAKER Davis & Wilson ADDRESS Kirkville Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1 PLACE OF DEATH

County Adair
 Township Clay
 or
 Village
 or
 City

Registration District No. 1023 File No.
 Primary Registration District No. 5006 Registered No. 19
 (NO. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John Quincy Adams

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M 4 COLOR OR RACE W 5 SINGLE MARRIED WIDOWED OR DIVORCED Married
 (Write the word.)
 6 DATE OF BIRTH
 (Month) (Day) 1 (Year)
 7 AGE
 If LESS than 1 day, hrs. or min.?
 yrs. mos. ds.
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

16 DATE OF DEATH Apr 29 1917
 (Month) (Day) (Year)
 17 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:

9 BIRTHPLACE
 (City or town, State or foreign country)
 10 NAME OF FATHER
 11 BIRTHPLACE OF FATHER
 (City or town, State or foreign country)
 12 MAIDEN NAME OF MOTHER
 13 BIRTHPLACE OF MOTHER
 (City or town, State or foreign country)

(Duration) yrs. mos. ds.
 CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) _____ M. D.
 _____, 191____ (Address)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____
 (Address) _____

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

15 Filed Apr 30 1917
 Registrar _____

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

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Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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