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

Do not use this space.

6448

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis Mo. (No. Barnes Hospital St. ..... Ward)

File No. .....

Registered No. 1656

2. FULL NAME Walter Grant Adams

(a) Residence. No. Shelbyville Mo St. 12 Ward. Shelbyville Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Dorthy Adams

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: about 57 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Shelbyville Mo

PARENTS

10. NAME OF FATHER: Walter G. Adams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ind

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ind

14. INFORMANT: Walter Raymond Adams
(Address) Shelbyville Mo

15. FILED FEB 17 1927 May C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2-15 1927

17. I HEREBY CERTIFY, That I attended deceased from 1-29, 1927, to 2-15, 1927 that I last saw him alive on 2-15, 1927, and that death occurred, on the date stated above, at 11 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chr. Myelogenous Leukemia

65a

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Pneumonia, lobar

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Autopsy

(Signed) Geo E. Nesche, M. D

, 19 (Address) Barnes Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Shelbyville Mo

DATE OF BURIAL: 2/18 1927

20. UNDERTAKER: J. H. Thompson

ADDRESS: Shelbyville Mo

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.