

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

Do not use this space.

9306

1. PLACE OF DEATH

County Randolph
Township Moberly
City Moberly

Registration District No. 735
Primary Registration District No. 3034
(No. Wabash Hospital)

File No. _____
Registered No. 49
St. 2nd Ward

2. FULL NAME

Martin C Adams
(a) Residence. No. 828 Concession St. 42 Ward.

(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch 25th 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 11 10 2 hrs.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman at Shops.
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ky
(STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER A

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

14. INFORMANT W. C. Bigelow
(Address) Moberly, Mo

15. FILED 3/6, 1927 Chas. J. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mch 3rd 1927

17. I HEREBY CERTIFY That I attended deceased from 4:46 1927, to 3-3- 1927
that I last saw h. l. alive on 3-3- 1927 and that death occurred, on the date stated above, at 11:55 8 1927 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

131
1/20/27
(duration) yrs. mos. ds.

CONTRIBUTORY Myocardial degeneration
(SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

18 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

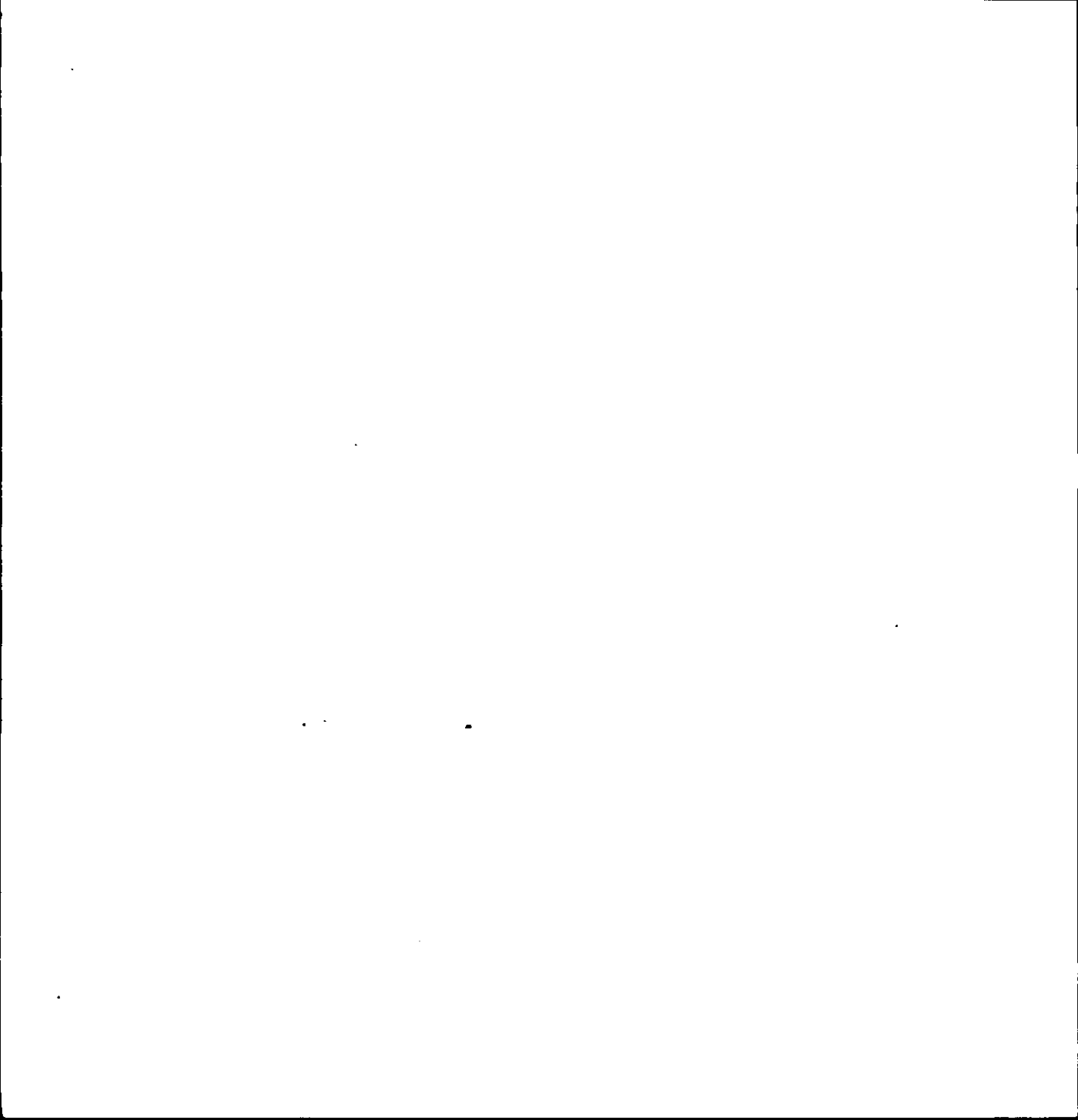
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. C. Streeton, M. D.
3-6, 1927 (Address) Moberly, Mo

*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 St. Carmel DATE OF BURIAL 3-6th 1927

20. UNDERTAKER Mahan and Son ADDRESS Moberly Mo



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Randolph
Township Moberly
City Moberly (No. St. Ward)

Registration District No. 733-
Primary Registration District No. 3034

File No.
Registered No. 49

2. FULL NAME

Martin C. Adams

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 25-1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 11 8

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT
(Address)

15.

FILED 3/6/27 Thos. S. Fleming
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 3- 19 27

17. I HEREBY CERTIFY, That I attended deceased from to
that I last saw him alive on 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

5-9328