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

Do not use this space.

18322

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Kaw — Primary Registration District No. 1002
City Kansas City (No. Old City Hosp. St. Ward)

File No. F 2425
Registered No.

2. FULL NAME John Adams
(a) Residence (Usual place of abode) No. 35 — & Brighton St., 1.14 Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 6-1892

7. AGE: Years 35 | Months 1 | Days 4 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(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): Miss

PARENTS
10. NAME OF FATHER: D.W. Adams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Miss
12. MAIDEN NAME OF MOTHER: Catherine Hoskins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Miss

14. INFORMANT: D.W. Adams
(Address) 3407 Colorado Ave

15. FILED June 14, 1927 M.M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6-10 1927

17. I HEREBY CERTIFY, That I attended deceased from 5-28, 1927, to 6-10, 1927, that I last saw h 5 30 pm live on 6-10, 1927, and that death occurred, on the date stated above, at 5 70 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
TBA
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 31
(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? No
WHAT TEST CONFIRMED DIAGNOSIS? Labratory
(Signed) H. M. Smith, M.D.
6-10-, 1927 (Address) Old City Hospital, Kansas City, 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: West Lawn Cem. — DATE OF BURIAL: 6-16-1927

20. UNDERTAKER: H. B. Moore — ADDRESS: 1820 E 18 St

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.