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

Do not use this space.

29554

File No.

Registered No. 1017

1. PLACE OF DEATH

County Buchanan Registration District No.

Township Primary Registration District No.

City St. Joseph, (No. 1821 Scott St. St. Ward)

2. FULL NAME Mary Adamack

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

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U.S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles Adamack

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 5, 1840

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	87	2	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(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) Bohemia

PARENTS

10. NAME OF FATHER John Patek

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

12. MAIDEN NAME OF MOTHER Anna Schafferneck

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

14. INFORMANT William Adamack

(Address) 1821 Scott St.

15. FILED Oct 6 1927 Registrar

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct, 4, 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1927 to Oct 4, 1927 that I last saw her alive on Oct 4, 1927 and that death occurred, on the date stated above, at 2.15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Endocarditis

29H

21H (duration) yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Comical

Weak Left Ventricle (duration) yrs. mos. 45 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? -

(Signed) A. E. Bingham, M. D

, 19 (Address) 1302 Faraon St.

*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 Mt. Mora Cemetery

DATE OF BURIAL Oct, 6, 1927

20. UNDERTAKER Walter Meierhoffer

ADDRESS 1302 Faraon St.

CAUSE ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... 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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH
County Buchanan — Registration District No. 85 — File No.
Township — Primary Registration District No. 1001 — Registered No. 1017
City St. Joseph (No. ..... St. ..... Ward)

2. FULL NAME Mary Adamack

(a) Residence. No. ..... St. ..... 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.

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)

PARENTS

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 11/2 19 27 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 4 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Endocarditis

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

CONTRIBUTORY (SECONDARY) Abscess Cervical gland, Lt. Side neck

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

18. WHERE WAS DISEASE CONTRACTED? probably tubercular
IF NOT AT PLACE OF DEATH? ..... cause
DID AN OPERATION PRECEDE DEATH? ..... DATE OF 3661
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) A. E. Bingham, M. D
, 19 (Address) St Joseph 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

S-29554