

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.

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

Do not use this space.

albee

30976

File No. _____
Registered No. 5-5- _____
St. _____ Ward _____

1. PLACE OF DEATH

County Millican

Registration District No. 561

Township Eldon

Primary Registration District No. 4330

City Eldon

(No. _____)

2. FULL NAME

(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

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

Clara J. Adkins

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

3-8-1850

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

47

7

7

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

Farmer Retiree

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

10. NAME OF FATHER

Anderson Adkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Mary Bell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

14.

INFORMANT
(Address)

Jona Adkins
Eldon

15.

FILED 11-1 19 27

Belle Haynes
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

10/15 19 27

17.

I HEREBY CERTIFY, That I attended deceased from 8/1/24

that I last saw him alive on 10/14/27, and that death occurred, on the date stated above, at 4:30 P.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intermittent Nephritis

CONTRIBUTORY (SECONDARY)

(duration) 1 yrs. mos. ds.

(duration) 5 yrs. mos. ds.

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. F. Albee, M.D.

, 19 (Address) Eldon 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

DATE OF BURIAL

Eldon Cemetery

10/17 19 27

20. UNDERTAKER

ADDRESS

W. G. Phillips

Eldon Mo

