FEB 21 1929

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

Do not use this space.

Di Rabmer

1085

File No. 13

Registered No. 13

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township

Primary Registration District No. 2001

City Springfield Mo (No. ; St., Ward)

2. FULL NAME Loren Adair

(a) Residence. No. 619 No Main 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): Married

5a. If Married, Widowed, or Divorced HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (month, day and year): April 17 - 1854

7. AGE: 74 Years, 8 Months, 17 Days. If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tenn

PARENTS
10. NAME OF FATHER: Billy Adair
11. BIRTHPLACE OF FATHER (city or town) (State or country): Tenn
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14. Informant: Mrs Addie Swearingen
(Address) Hwy 2 Glenstone
Route 7 Box 143

15. Filed 1-5 1929 OC Horst MD Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day and year) 1 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1928, to Jan 4th 1929, that I last saw him alive on 1-4- 1929, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
131
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY) Broncho Pneumonia (duration) ... yrs. ... mos. 3 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) H J Rabman, M.D.

, 192 (Address) Land Bank Bldg

*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: Green Hill
DATE OF BURIAL: Jan 6 1929

20. UNDERTAKER: T M Bohmyer
ADDRESS: SPRINGFIELD, 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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