

APR 30 1929

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County St. Louis
 Township Current River
 City St. Louis (No. 4)

Registration District No. 750
 Primary Registration District No. 5986

File No. 9
 Registered No. 892
 St. St. Louis Ward 4

2. FULL NAME

(a) Residence. No. 1 St. St. Louis Ward 4
 (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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

Single

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

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1
 day, ... hrs.
 or min.

7

7

unknown

8. OCCUPATION OF DECEASED

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

School girl

(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)

MO

10. NAME OF FATHER

Oscar Adams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

MO

12. MAIDEN NAME OF MOTHER

Blanche Harris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Cen. Ill.

14.

INFORMANT
 (Address)

John A. Adams
 501 N. 1st St.
 St. Louis, Mo.

15.

FILED

4-8-29 E. B. Johnston
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/28 1929

17.

I HEREBY CERTIFY, That I attended deceased from 1/21
 1929, to 1/28 1929,
 that I last saw her alive on 1/28 1929, and that
 death occurred, on the date stated above, at 8:00 A.M., Chicago.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Craschophrenomania
 11A

CONTRIBUTORY (SECONDARY)

4 months
 (duration) 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. B. Waddell, M. D.

1/28 1929 (Address) 501 N. 1st St. St. Louis, 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

Pratt Cem

1-27 1929

20. UNDERTAKER

ADDRESS

none

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.

[illegible]

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**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 Cape Girardeau

Registration District No. 730

Township Current River

Primary Registration District No. 3-986

City Deane (No.)

File No.

Registered No. 892

St. Ward

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

F

4. COLOR OR RACE

W

**5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)**

S

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

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

7-3-1929

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

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

**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

4/8-29

E B Johnston

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

1-26-1929

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:

**CONTRIBUTORY
(SECONDARY)**

(duration) yrs. mos. ds.

(duration) 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. 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

REGISTRATION CH. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

if supplied. Age, sex, he properly classified.

S-3125-4