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

Do not use this space.

5600

MAR 21 1929

85

1. PLACE OF DEATH

County Buchanan Registration District No. Primary Registration District No. 1001 File No. Registered No. 369

Township City St. Joseph, (No. St. Joseph's Hospital St. Ward)

2. FULL NAME Ella Adam,

(a) Residence. No. 1008 Church St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 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)
Female	White	Single,

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 22, 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	69	9	6	

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) Rock Island,
(STATE OR COUNTRY) Illinois,

PARENTS

10. NAME OF FATHER James Adam,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Glassgow,
(STATE OR COUNTRY) Scotland,
12. MAIDEN NAME OF MOTHER Ella Agnes Stewart,
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Rock Island,
(STATE OR COUNTRY) Illinois,

14. INFORMANT Miss Kate Adams
(Address) 1008 Church Street.

15. FILED MAR 2 1929 John G. Ott REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Fe 23 1929, to Fe 28 1929,
that I last saw h... alive on ..., 19..., and that
death occurred, on the date stated above, at 5 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar pneumonia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? St Joseph Mo
DID AN OPERATION PRECEDE DEATH? N.A. DATE OF 0
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination

(Signed) F. H. Mowbray, M. D
(Address) 825 Charles

*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
Mount Mora Cemetery	Mch. 2nd. 19 29
20. UNDERTAKER	ADDRESS
Heaton-Bigsby-Bowman by J.H. Heaton	319 S. 10 St. Funeral Home

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.