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

Do not use this space.

9175

1929

1. PLACE OF DEATH

County: Shelby — Registration District No.: 830

Township: Salt River — Primary Registration District No.: 4091

City: Shelbina (No. ..... St. ..... Ward)

File No.: 13

Registered No.: .....

2. FULL NAME William Otis Adams

(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: m

4. COLOR OR RACE: W

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): Jan 2 1860

7. AGE

Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
69	1	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired Farmer

(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) Monroe Co Mo

PARENTS

10. NAME OF FATHER Newton Adams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky Henry Co

12. MAIDEN NAME OF MOTHER Martha M Sparks

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Henry Co Ky

14. INFORMANT: Jane Adams
(Address) Kansas City Mo

15. Feb 11, 1929 Nellie Gooch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 8 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929, to Feb 8, 1929, that I last saw him alive on Feb 8, 1929, and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Rupture of Gall bladder
followed by Peritonitis
8 hrs
Fever
104

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

CONTRIBUTORY (SECONDARY): None in common diet

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

18. WHERE WAS DISEASE CONTRACTED? .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb 7-29
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Exploratory Lap.
(Signed) J. A. Gunnell, M. D
, 19 (Address) Shelbina, 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: IOOF cem — DATE OF BURIAL: Feb 10 1929

20. UNDERTAKER: E Hayes — ADDRESS: Shelbina

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.