32 MAY 24 1929

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

Do not use this space.

14280

1. PLACE OF DEATH

County Dekalb Registration District No. 264 File No.

Township Grant Primary Registration District No. 5367 Registered No.

City Maysville St. Ward)

2. FULL NAME Lucinda Adamson

(a) Residence. No. Maysville Mo St. Ward 2 (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 32 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2 1837

7. AGE Years 91 Months 10 Days 21 If LESS than 1 day, ...hrs. or ......min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Ind

PARENTS

10. NAME OF FATHER Wm McCammon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ind

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT J A Adamson
(Address) Maysville Mo RR 4

15. FILED May 10, 1929 Mrs. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-23 1929

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 23 1929, that I last saw h...... alive on ......, 19......, and that death occurred, on the date stated above, at 4 P m.

THE CAUSE OF DEATH* was as follows:

Cerebral arterio Sclerosis

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

CONTRIBUTORY (SECONDARY) ......(duration) ......yrs. ......mos. ......ds.

91B

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) L E Blackburn, M. D

4/24, 1929 (Address) King City, 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 Grayfort Cem.
DATE OF BURIAL 4-25 1929

20. UNDERTAKER R. P. Taggart
ADDRESS King City

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

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.

Carter 263 2 2 31