

27 1929

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

Do not use this space.

15162

1. PLACE OF DEATH

County.....Johnson  
Township.....Warransburg,  
City.....(No..... Ward)

Registration District No. 431  
Primary Registration District No. 5588

File No.....  
Registered No.....  
St..... Ward)

2. FULL NAME Cynthia Evaline Adair

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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 J. R. Adair

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 22, 1850

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 78 4 6

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) Missouri.

10. NAME OF FATHER John Smith

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

12. MAIDEN NAME OF MOTHER Unknown,

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

14. INFORMANT J. R. Adair, (Address) Warrensburg, Mo

15. FILED 4/29 1929 J. R. Adair REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from [unclear] 1929, to April 28, 1929 (that I last saw h..... alive on..... 9-30 19..... and that death occurred, on the date stated above, at..... A.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: Clear myocardial infarction

CONTRIBUTORY (SECONDARY) JAB (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? [unclear]

(Signed) [unclear] M. D. Address [unclear]

\*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 Sunset Hill Cemetery 4/29 1929

20. UNDERTAKER ADDRESS R. A. Phillips Warrensburg Mo.

N. B.—Every item of information should be carefully supplied. AGS 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.

