

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

Do not use this space.

17539

1. PLACE OF DEATH

County Cass
Township Grand River
City Harrisonville (No. _____)

Registration District No. 156
Primary Registration District No. 5219

File No. _____
Registered No. 25
St. _____ Ward _____

2. FULL NAME

Rachel O. Adkins

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. — mos. — da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>George S. Adkins</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Sept 9-1849</u>		
7. AGE <u>79</u>	YEARS <u>7</u>	MONTHS <u>29</u>
		DAYS <u>29</u>
		If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Howard

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

12. MAIDEN NAME OF MOTHER Temper Hamilton

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

14.

INFORMANT Lora A. Allen
(Address) Harrisonville, Mo.

15.

FILED 5/9/29 AS Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from March 27 1929 to May 8 1929
that I last saw her or alive on May 7 1929, and that death occurred, on the date stated above, at 9 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uraemic coma
with chronic nephritis

CONTRIBUTORY (SECONDARY)

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) J. H. Scott M. D.
, 19 (Address) Harrisonville, 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

210 1929

20. UNDERTAKER

ADDRESS

Reubenburger Bros

Harrisonville

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.

