

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

Do not use this space.

21333

1. PLACE OF DEATH

County Boonville
Township Boonville
City Boonville (No. _____)

Registration District No. 393
Primary Registration District No. 5548

File No. _____
Registered No. 8
St. _____ Ward _____

2. FULL NAME

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

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

Margaret Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>96</u>	<u>1</u>	<u>2</u>	<u>2</u>	

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) Belgrade
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Christopher Woods.

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

12. MAIDEN NAME OF MOTHER Ruby Bryan

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

14. INFORMANT Frank Adams.
(Address) Goodland Mo.

15. FILED July 8, 1929 Belle Pippin
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30, 1929

17. I HEREBY CERTIFY, That I attended deceased from about _____, 1925, to June 30, 1929, that I last saw him alive on June 30, 1929, and that death occurred, on the date stated above, at 2:48 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of breast
50
16.2
about (duration) 4 yrs. mos. ds.
CONTRIBUTORY Old age
(SECONDARY) (duration) _____ yrs. mos. ds.

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) Dr. J. R. Adams, M. D.
, 19 _____ (Address) Goodland 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 Goodland Mo. DATE OF BURIAL July 1929

20. UNDERTAKER Johnson White & Son ADDRESS Fronton

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.

1929

... it may be necessary to ...
... of the ...
... of the ...

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Iron Registration District No. 393 File No. _____
 Township Cent Primary Registration District No. 3548 Registered No. 8
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME

Margarett 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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 28</u>		
7. AGE <u>96</u>	YEARS <u>1</u>	MONTHS <u>2</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (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) _____

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED July 27 1927 Belle Pappin X
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1927
 17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 _____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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) _____, M. D.
 _____, 19____ (Address) _____

*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 19____
20. UNDERTAKER	ADDRESS _____

SUPPLEMENTARY

REGISTRAR SHALL NOT RECEIVE A FEE FOR THIS CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 N. E. CAUSE
 applied. properly clear
 that is on

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