

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

Do not use this space.

43039

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **703**

City **St. Louis**

No. **5423 Oriole Ave**

File No.....

Registered No. **49**

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. **5423 Oriole Ave** St. **7** Ward _____

(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 **Female** 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 **Georgine S. Adams (widow)**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 17, 1855**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 1 14

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). **Dry Goods and Shoe Store**
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Penn**

10. NAME OF FATHER **William Adams**

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

12. MAIDEN NAME OF MOTHER **Rather**

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

14. INFORMANT **Mrs. Georgine S. Adams**
(Address) **5423 Oriole Ave**

15. JAN -2 1930 FILED **Max E. Stander**

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 31 1929**

17. I HEREBY CERTIFY, That I attended deceased from **Jan 1st 1929** to **Nov 29th 1929** and that I last saw him alive on **Nov 29th 1929** and that death occurred, on the date stated above, at **8:30 p. m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Valvular disease of the heart
52A
16R (duration) **2 yrs. mos. ds.**

CONTRIBUTORY **Senile Debility**
(SECONDARY) (duration) **yrs. mos. ds.**

18. WHERE AND DISEASE CONTRACTED **PA**
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **usual tests.**
(Signed) **Goldburn & Wilson** M. D.

(Address) **4105 H. St. Kansas 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 **St. Peters** DATE OF BURIAL **Jan 3 1930**

20. UNDERTAKER **Math. Hermann & Son** ADDRESS **2161 E. Fair Col.**

K. E.—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.

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MISSOURI STATE BOARD OF HEALTH—THIS IS A PERMANENT RECORD

