

WAR 25

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

Do not use this space.

617-A

1. PLACE OF DEATH

County *Cooper*
Township *Prarie Home*
City (No.) (Ward)

Registration District No. *224*
Primary Registration District No. *5305*

File No.
Registered No. *1*
St. Ward

2. FULL NAME *Peter Roy Adair*

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

Length of residence in city or town where death occurred yrs. *65* mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 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 *minnie Adair*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 6 - 1864*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 8 29

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Farmer*
(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 *Wm Adair*

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

12. MAIDEN NAME OF MOTHER *Mary L Schoff*

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

14. INFORMANT *Minnie Adair*
(Address) *Prarie Home mo.*

15. FILED *1-2-30* BY *Dr A & Wurdth* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-2* 19 *30*

17. I HEREBY CERTIFY That I attended deceased from *Dec 10* 19 *29* to *1-2-30* 19 *30* that I last saw him *alive* on *12-20-29* 19 *29* and that death occurred, on the date stated above, at *3 0* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chr Valvular Dis
Heart
92 B (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *90 W* (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *A & Wurdth* M. D.
1-2-30 (Address) *Prarie Home 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
Providence Cem. *1-3* 19 *30*

20. UNDERTAKER ADDRESS
Calbert Hornbeck Prarie Home mo

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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