

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.

MAR 27 1930

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

Do not use this space.

9287

1. PLACE OF DEATH

County Laclede  
Township Franklin  
City Laclede (No. \_\_\_\_\_)

Registration District No. 952  
Primary Registration District No. 3617

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

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

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

7

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

Robin Adams

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

Jan 20-1836

7. AGE

YEARS

94

MONTHS

1

DAYS

17

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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)

Clay Co Ill

10. NAME OF FATHER

Wilson Jordan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

England

12. MAIDEN NAME OF MOTHER

Elizabeth Harnet

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't know

14.

INFORMANT

(Address)

Otis Adams

Osla mo

15.

FILED

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3.7 - 1930

17.

I HEREBY CERTIFY, That I attended deceased from Aug 1929. 6 on 3-8 1930 that I last saw her alive on 3-2 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Bronchial Pneumonia

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. W. Hinds, M. D.

, 19 (Address) Conway

\*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

McBride Cemetery 3/8 1930

20. UNDERTAKER

ADDRESS

Holman & Stewart Lebanon mo

④

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

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Laclede

Registration District No. 95-2

File No. ....

Township Franklin

Primary Registration District No. 9-617

Registered No. ....

City Louisville

(No. ....)

St. ....

Ward) ....

**2. FULL NAME**

(a) Residence. Louisville

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**

F

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

wid

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

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

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

**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)

**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

Mar 30 1930 Isabelle Lewis  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

Mar 7 1930

**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:

**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).....

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**

WRITE PLAINLY, WITH COPYING 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

9287