16615-a

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

Do not use this space.

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1. PLACE OF DEATH
County Lawrence
Township Lincoln
City Miller (No. ..... St. ..... Ward)

Registration District No. 469
Primary Registration District No. 5-630

File No. .....
Registered No. 13

2. FULL NAME Sarah Adamson

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
f	w	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-10-1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	70	2	11	

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) Ark.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER James Neill
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mayfield
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark.
(STATE OR COUNTRY)

14. INFORMANT Mrs Merta Turk
(Address)

15. FILED 8-21, 1930 W. S. Bruns REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-24 1930

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930 to 5-24, 1930 that I last saw her alive on 8-24, 1930 and that death occurred, on the date stated above, at C.P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cystitis
106A
194B
135B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fractured femur
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clin. symp.
(Signed) W. S. Bruns, M. D.
, 19 (Address) Miller 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
Gum Cemetery	5-23-1930
20. UNDERTAKER	ADDRESS
J. W. Morris & Leiman	Miller Mo.

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.

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 Lawrence — Registration District No. 469 — File No. .....

Township Lincoln — Primary Registration District No. 5630 — Registered No. 13

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Sarah Adamson

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	M

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)

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 ....., 19 W. S. Bunney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 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:
Cystitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fractured femur from a fall on floor

..... (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)

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*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

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 COMPLETELY PRESCRIBED BY LAW

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