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

1851 5

1. PLACE OF DEATH
County Audrain Registration District No. 24 File No.
Township Salt River Primary Registration District No. 3007 Registered No. 72
City (No. St. Ward)

2. FULL NAME William Henry 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
6. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) WIFE OF: Sarah L Adams
7. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 23rd 1852
8. AGE — Years: 78 Months: 4 Days: 11 If LESS than 1 day, ..... hrs. or ..... min.
9. 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:
BIRTHPLACE (CITY OR TOWN):
(STATE OR COUNTRY): Iowa
10. NAME OF FATHER: William Adams
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Ky
12. MAIDEN NAME OF MOTHER: Miller
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Ky
INFORMANT: Mrs Sarah Adams
(Address): Wife

Filed June 10th 1930 Ira S Williams REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 4 1930
17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to June, 1930, that I last saw h. living alive on May 5, 1930 and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Colon Ulcers - Probably Malig
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Enlarged Prostate
(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? Clinical
(Signed) H E Robertson, M D
, 19 (Address) Mexico 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. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL |
|---|---|
| Bethel Mo | June 5 1930 |
| 20. UNDERTAKER | ADDRESS |
| Snyder & Hangen | Centralia 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.

V. S. No. 2.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No..... ..... St. ..... Ward.....

2. FULL NAME .....

(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.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| | | |

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. |
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(a) Trade, profession, or particular kind of work .....

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(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..... REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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.....

.....

.....

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

CONTRIBUTORY.....
(SECONDARY)

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

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