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

Do not use this space.

33209

1. PLACE OF DEATH
County Jackson
Township Kaw
City K. C. MO. (No. 1912 E. 19 St. ..... Ward)
Registration District No. 399
Primary Registration District No. 1007
File No.
Registered No. 4552

2. FULL NAME Sam Adams
(a) Residence. No. 1912 E. 19 St., 4 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 M
4. COLOR OR RACE Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch 1878
7. AGE YEARS 52 MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) Flat Bldg
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tex
PARENTS
10. NAME OF FATHER Sam Adams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tex
12. MAIDEN NAME OF MOTHER Martha Rushing
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.
14. INFORMANT Martha Adams
(Address) 1912 E. 19 St.
15. FILED 11/10, 1930 M. M. Crowe REGISTRAR Asst

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 31 - 1930
17. I HEREBY CERTIFY, That I attended deceased from Oct. 30 - 1930 to Oct. 31 - 1930 that I last saw him alive on Oct. 30, 1930 and that death occurred, on the date stated above, at 3 A. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
106 (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (SECONDARY) Subacute Bronchitis (duration) ..... yrs. 1 mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? No
(Signed) F. J. Haugh, M. D.
11/1, 1930 (Address) 2700 E. 18

*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 Blue Ridge Lawn Cem.
DATE OF BURIAL Nov. 10th 1930
20. UNDERTAKER West, Appleton & Jones
ADDRESS 1600 E. 19 St.

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.