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

Do not use this space.

File No. 34500

Registered No. 9876

Registration District No. 1003

Primary Registration District No. 791

1. PLACE OF DEATH

County

Township

City St. Louis, Mo. (No. City Hospital #2 St. Ward)

2. FULL NAME John Adams

(a) Residence. No. 1128 N. Newstead St., N Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 11 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)
Male	Col	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-1-1907

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	23	4	12	

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)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.

PARENTS

10. NAME OF FATHER William Adams

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

12. MAIDEN NAME OF MOTHER Henrietta Johnson

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

14. INFORMANT A. Gertrude Creath
(Address) City Hospital #2

15. FILED 10-13 1930 Max C. Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-13-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-12, 1930, to 10-13, 1930 that I last saw h. alive on 10-13, 1930, and that death occurred, on the date stated above, at 8:20 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
2-4 (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Unknown (duration) yrs. mos. ds.

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

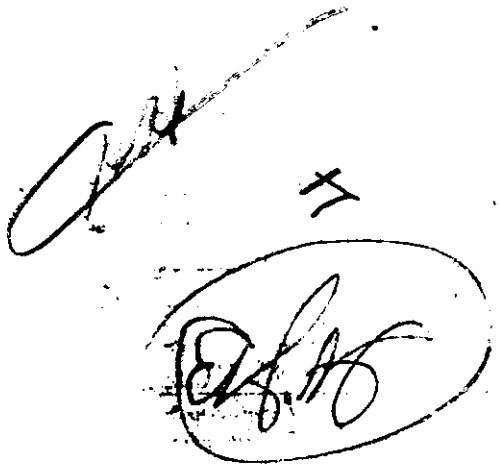
DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical-X-RAY-Lab.

(Signed) Henry C. Farrington, M. D.

10-13-1930 (Address) City Hosp. #2

*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
Carondelet Mass	10-17 1930
20. UNDERTAKER: J. S. Hecht Funeral Co	ADDRESS 4202 Finney