

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

Do not use this space.

✓

14537

**1. PLACE OF DEATH**

County Jackson  
 Township Washington  
 City Keosauqua (No. 8009)

Registration District No. 404  
 Primary Registration District No. 5558  
Agnes

File No. \_\_\_\_\_  
 Registered No. 22  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 8009 Agnes 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-26-1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.  
75 | 4 | 5

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) MO

10. NAME OF FATHER Giles Adams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) MO

12. MAIDEN NAME OF MOTHER Eliza Capp

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) MO

14. INFORMANT Mr W H Smith (Address) 8006 Agnes

15. FILED 4-2-1931 B. F. Brainerd REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr-1-1931

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920, to Apr 1, 1931, that I last saw him alive on Mar 31, 1931, and that death occurred, on the date stated above, at 10:25 am.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Lobar Pneumonia  
108 (duration) yrs. mos. da. 5

CONTRIBUTORY (SECONDARY) 108 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) Les Jones, M. D.  
4/15, 19 (Address) 804 1/2 Case

\*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 Wardens Mo DATE OF BURIAL 4-2-31

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. C. 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.

APR 25 1931

RECORD

807-4 P. 1000