

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

Do not use this space.

14719

**1. PLACE OF DEATH**

County Laclede  
Township Lebanon  
City Lebanon (No. 1)

Registration District No. 449  
Primary Registration District No. 5684

File No. 1647  
Registered No. 1647  
St. 1 Ward 1

**2. FULL NAME** Abner Adkins

(a) Residence, No. 1 St. 1 Ward 1  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U.S., if of foreign birth? yrs. 1 mos. 10 ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Edith Lowery</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 21 1842</u>		
7. AGE <u>88</u>	YEARS <u>7</u>	MONTHS <u>13</u>
		DAY <u>13</u>
		If LESS than 1 day, <u>hrs.</u> <u>or</u> <u>min.</u>

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farm  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lebanon Mo.  
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Abner Adkins</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Lebanon</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER <u>Hooper</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Lebanon</u> (STATE OR COUNTRY)

14. INFORMANT Lewis Adkins  
(Address) Lebanon Mo.

15. FILED 4/3 1931 J. M. Bellamy  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 2 1931  
17. I HEREBY CERTIFY, That I attended deceased from March 1st to April 2 1931, and that I last saw him alive on April 1 1931, and that death occurred, on the date stated above, at 10:00 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Influenza  
11 B  
162 (duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (SECONDARY) Age  
(duration) 88 yrs. 8 mos. 13 ds.

**18. WHERE WAS DISEASE CONTRACTED**

11 B  
NOT AT PLACE OF DEATH  
DID AN OPERATION PRECEDE DEATH? no DATE OF no  
WAS THERE AN AUTOPSY? Phys. Exam  
WHAT TEST CONFIRMED DIAGNOSIS? Phys. Exam  
(Signed) J. H. Slattery M. D.  
(Address) Lebanon 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 Adkins Cem. DATE OF BURIAL 19

20. UNDERTAKER Adkins ADDRESS Lebanon Mo.

Every item of information 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.

MAY 25 1931

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**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 Laclede  
Township Lebanon  
City Lebanon (No. ....)

Registration District No. 449  
Primary Registration District No. 5689

File No. ....  
Registered No. 1647  
St. .... Ward

**2. FULL NAME**

Abner Adkins

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) 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)

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 6/2 1931 J. M. Billings REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 2 19 31

17. I HEREBY CERTIFY, That I attended deceased from ..... to .....  
that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (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)

\*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

20. UNDERTAKER ADDRESS

4/4 1931

N. B.—very 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. REGIS.—RS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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