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.

33167

File No. 33167
Registered No. 10071

1. PLACE OF DEATH

County ..... Registration District No. 791
Township ..... Primary Registration District No. 1008
City St. Louis (No. City Hospital St. ..... Ward)
9137

2. FULL NAME Marion Adams

(a) Residence, No. 1844 So. 10th St., 23 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 5 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	white	single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 26-1931

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	5		

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. nil

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Missouri

FATHER

13. NAME James Adams

14. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Pearl Eulow

16. BIRTHPLACE (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

17. INFORMANT Hospital Information
(ADDRESS) City Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mineral Point, Mo DATE Sept. 29 1931

19. UNDERTAKER Allen W. McLaughlin
(ADDRESS) 1631 Mo. Ave.

20. FILED SEP 29 1931 19 Mary C. Harlen
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 26th 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug. 24th 1931, to Sept. 26th, 1931
I last saw h... alive on Sept. 26, 1931. Death is said to have occurred on the date stated above, at 12.30 m. P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
1193	
1 Marasmus	

Other contributory causes of importance:

Gastro enteritis

Name of operation ..... Date of .....
What test confirmed diagnosis? Clin. Obs. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) J. J. Buchman, M. D.
(Address) City Hospital

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Accuracy from 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.

REGIST... RECEIVE A FEE FOR CERTIFICATES U... ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

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

Township..... Primary Registration District No..... Registered No. 10071

City..... (No. City Hosp. St. .....Ward)

2. FULL NAME Marion Adams

(a) Residence. No. 1844 S 10 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: F

4. COLOR OR RACE: W

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) April 26/1931

7. AGE: YEARS ... MONTHS 5 ... 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) Mineral Springs
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTY)

14.
INFORMANT .....
(Address)

15. NOV -9 1931
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 26, 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

S-33167