

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

Do not use this space.

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38340

1. PLACE OF DEATH

County Miller Registration District No. 564
Township Equality Primary Registration District No. 3758
City Independence (No.) St. Ward)

2. FULL NAME Adelaide Calbert

(a) Residence, No. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) aug/4 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 3 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 0
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 0
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Elizabeth

FATHER 13. NAME William Wade

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Thomas Cal County

MOTHER 15. MAIDEN NAME Marianda Wade

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Gott Cemetery DATE Dec 19 1931

19. UNDERTAKER (ADDRESS) Edwin Green

20. FILED 19

Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-17 1931

22. I HEREBY CERTIFY, That I attended deceased from Jan 1931, to Nov 17 1931
I last saw him alive on 11-17-31 Death is said to have occurred on the date stated above, at 7:40 m.

The principal cause of death and related causes of importance were as follows:

Valvular Disease
92A - 29
162
Other contributory causes of importance:
92A - 29
162

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) St Thomas M. D.
(Address) Independence MO

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.

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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 Miller
Township Equality
City (No.)

Registration District No. 364
Primary Registration District No. 3758

File No.
Registered No.
St. Ward

2. FULL NAME

Adelaide Calbert

(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>wid</u>
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.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	11. Total time (years) spent in this occupation
	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)	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER FATHER
13. NAME

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

MOTHER FATHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 11-18-31 J. Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/17 1931

22. I HEREBY CERTIFY, That I attended deceased from to , 19 .
I last saw h. alive on , 19 . Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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) , M. D.
(Address)

SUPPLEMENTARY

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.
 EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.
 PHYSICIAN SHOULD BE CAREFUL TO REPORT EXACTLY.
 DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFYING DEATHS UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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