

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

9501

1. PLACE OF DEATH

County Penicook
Township Penicook
City St. Louis (No. _____)

Registration District No. 63-1
Primary Registration District No. 3-863

File No. _____
Registered No. 42
St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-12-1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 0 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 171
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Grovers
(STATE OR COUNTRY) Miss

10. NAME OF FATHER Calhoun Adams

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

12. MAIDEN NAME OF MOTHER Eveline Thomas

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

14. INFORMANT T. H. Adams
(Address) Steele mo

15. FILED Apr 18 1932 Ada Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5-1932

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pulmonary Tuberculosis
(duration) 1 yrs. 4 mos. da.

CONTRIBUTORY (SECONDARY) none
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Arkansas
(IF NOT AT PLACE OF DEATH)

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical history
(Signed) James P. Hickney M. D.
3-5-1932 (Address) Steele mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDE, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gericho ark
DATE OF BURIAL 3-7-1932

20. UNDERTAKER Roberson mort. ADDRESS Gericho Ark

1. PLACE OF DEATH

County.....

Township.....

City..... (No.

Registration District No.

Primary Registration District No.

File No.

Registered No.

St. Ward)

2. FULL NAME

(a) Residence. No.
(Usual place of a body)

Length of residence in city or town where death occurred yrs. mos.

St. Ward.

(If nonresident, give city or town and State)

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)

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....., 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from.....

that I last saw h..... alive on....., 19....., 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.

(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).....

, 19 (Address)

M. D.

*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

19