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

Do not use this space.
32005 Williams

NOV 23 1932

1. PLACE OF DEATH
39 County Greene — Registration District No. 318 2001 — File No.
3 Township 1 — Primary Registration District No. — Registered No. 731
5 City Springfield Mo. (No.) Tubercular Hospital St. Ward)

2. FULL NAME Mrs. Ethel A. Adams

(a) Residence, No. 1519 E. Cherry St., Ward. (If nonresident, give city or town and State)
(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.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, ~~WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF Earl B. Adams

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 9-1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	39	7	14	

OCCUPATION

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 217

10. Date deceased last worked at this occupation (month and year) August 1929 — 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no data 21

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT Mrs. Alma Lohmeyer (ADDRESS) Springfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Oct. 24 1932

19. UNDERTAKER Alma Lohmeyer & Home (ADDRESS) Springfield Mo.

20. FILED 10-24 1932 Ralph Lindangston Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 23 1932

22. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1932, to Oct. 23, 1932
(I last saw her alive on Oct 19, 1932. Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Tuberculosis	
2-3-4, 23	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Physical Exam. 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? No
If so, specify .....

(Signed) C. H. Williams, M. D.
(Address) Springfield, Mo.