

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

Do not use this space.

1483  
213

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township Kearney Primary Registration District No. \_\_\_\_\_  
City Keokuk (No. 1216 E. Armour) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 1216 E. Armour St. 17 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<br><u>Se</u>  | 4. COLOR OR RACE<br><u>Wh.</u>   | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>Widowed</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF<br><u>John F. Adams</u> |  |   |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)  |  |   |
| 7. AGE<br><u>82</u>  | 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.<br><u>At Home.</u> |   |
|  | 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  |   |

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 14 - 1933

22. I HEREBY CERTIFY, that I attended deceased from August - 2, 1931, to Jan 14, 1933

I last saw him alive on Jan 13, 1933 Death is said to have occurred on the date stated above, at 30 a.m.

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

Bronchial Pneumonia Date of onset 1-7-33  
131  
10/11/31

Other contributory causes of importance:  
Refractive Chronic Intestinal 15 yrs

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? Cerebral Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? none  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

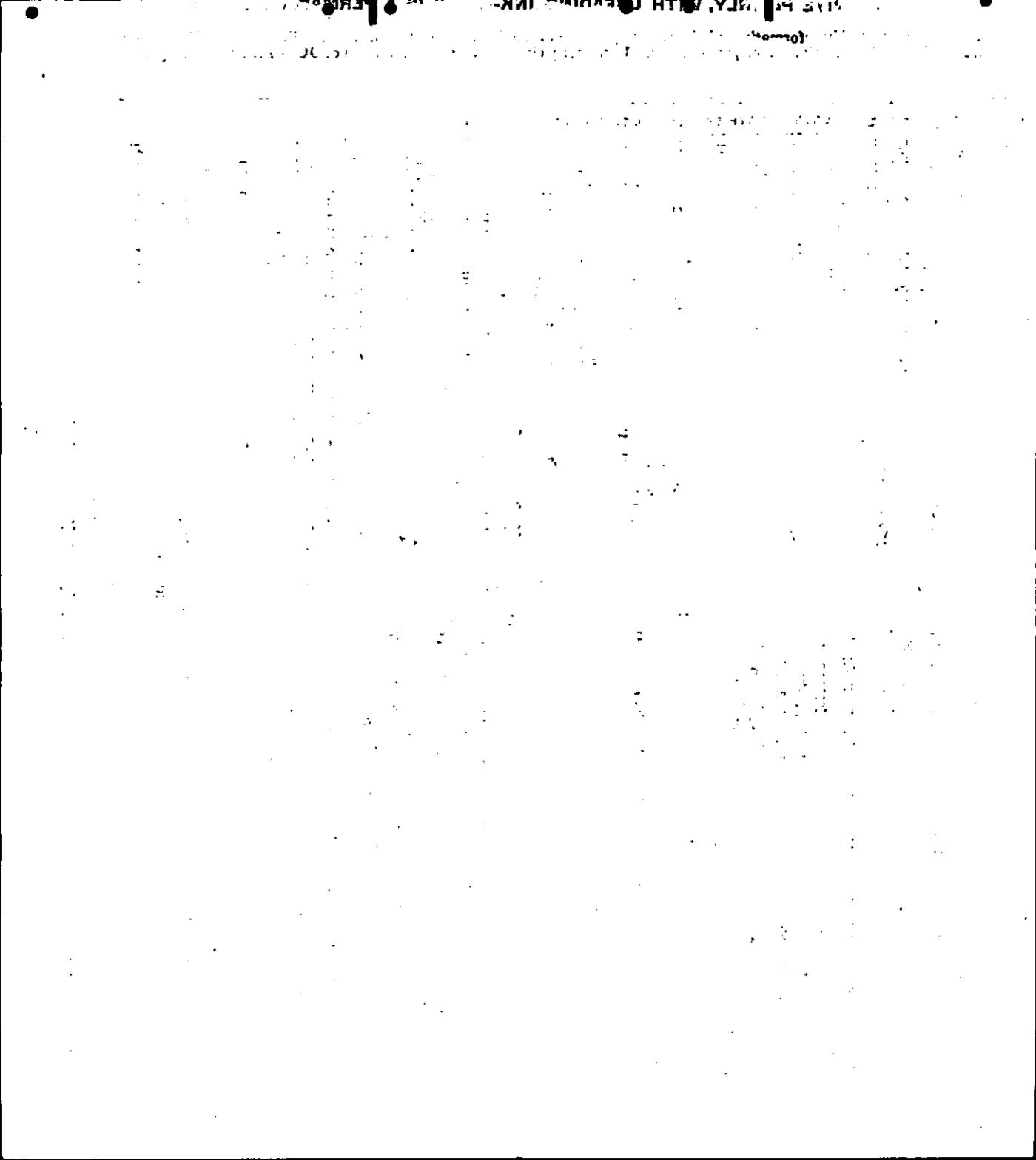
Manner of injury none  
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_  
(Signed) W. J. Hallahan, M. D.  
(Address) 1132 Woodland Ave. Keokuk, Ia.

|  |   |
|--|---|
| FATHER   | 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Richmond Ind</u> |
|  | 13. NAME<br><u>Watson</u>   |
| MOTHER   | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Ill.</u>         |
|  | 15. MAIDEN NAME<br><u>Sarah Watson</u>                                  |
|  | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Ill.</u>         |
|  | 17. INFORMANT (ADDRESS)<br><u>J. P. Davis</u>                           |
| 18. BURIAL, CREMATION, OR REMOVAL PLACE<br><u>Keokuk, Ill.</u> DATE <u>1-16-33</u> |   |
| 19. UNDERTAKER (ADDRESS)<br><u>J. P. Davis Funeral Home, 3400 Woodland Ave.</u>    |   |
| 20. FILED <u>1-14</u> 19 <u>33</u> <u>M. M. Crowe</u> <u>Asst Registrar.</u>       |   |

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

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....  
Township.....  
City Kansas City (No.....)

Registration District No. 399  
Primary Registration District No. 1002

File No.....  
Registered No. 213  
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. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown

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

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

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) (STATE OR COUNTRY)

13. NAME

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

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 1/14 1933 M. M. Brown Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 14, 1933

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:

Date of onset

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**

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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