

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

Do not use this space.

11568

APR 25 1934

PLACE OF DEATH
County Scott Registration District No. 820
Township Sylvania Primary Registration District No. 4496
City Oran (No. _____ St. _____ Ward _____)

File No. _____
Registered No. _____

2. FULL NAME Charles Francis Adams
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 10 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 Male 4. COLOR OR RACE Caucas 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Adams
Arthur A. Miller
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febr 15 - 1873
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 1 9

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Tampico
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER Frank Adams
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Caroline Graham
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) South Carolina
(STATE OR COUNTRY) _____

14. INFORMANT Carra Adams
(Address) Oran Mo

15. FILED 49, 19 34 Wickham
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/26th 1934

17. I HEREBY CERTIFY, That I attended deceased from Mich, 1934, to Mich 26, 1934 that I last saw him alive on 3/26th, 1934, and that death occurred, on the date stated above, at 7-15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Dilatation of
Heart. Valvular in-
sufficiency
(duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Suppurative and Active
Life (duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED S. E. Mo 92A

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) H. S. Winters, M. D.

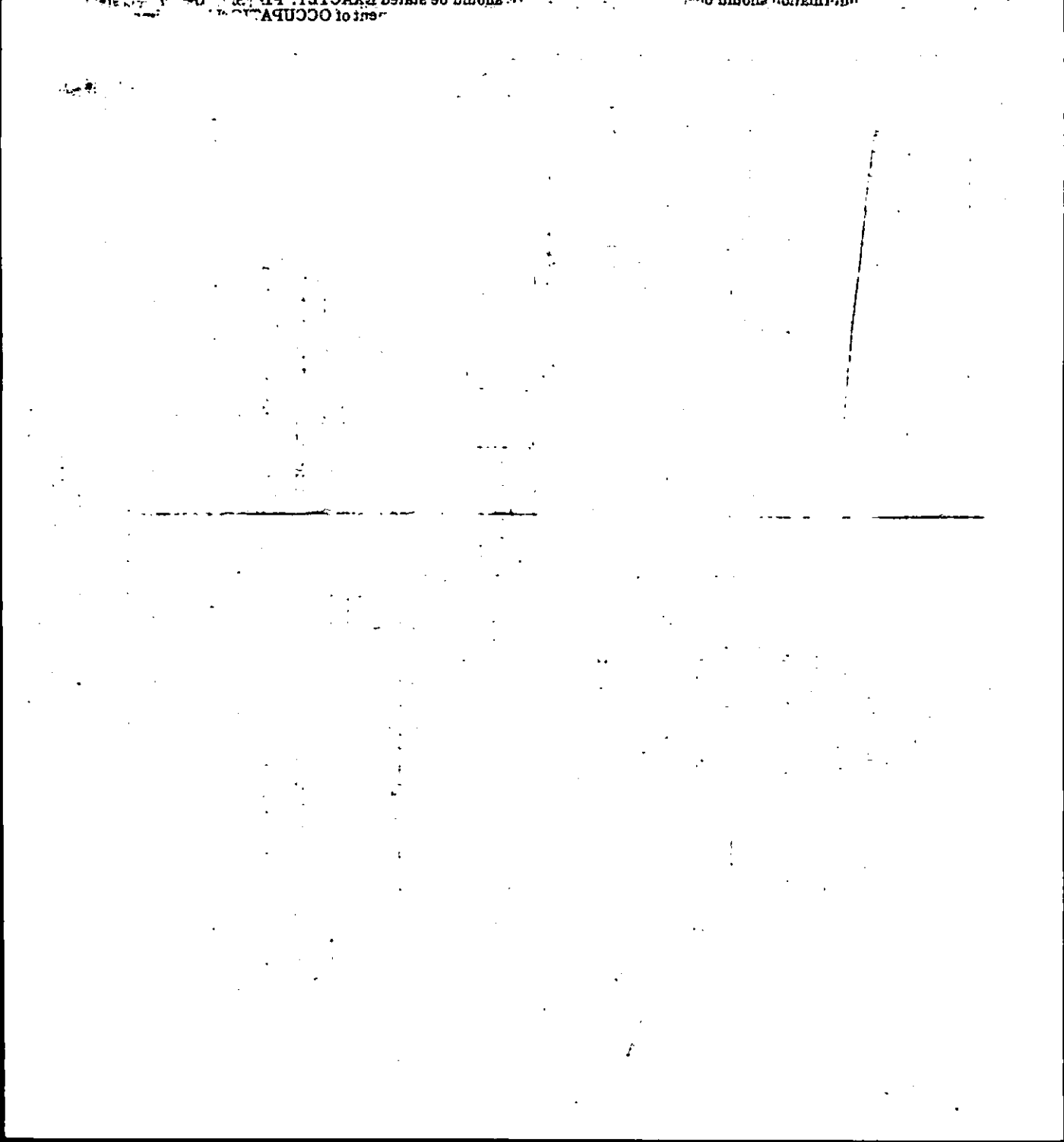
. 19 (Address) Oran Mo

*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 Oran Cemetery DATE OF BURIAL 3/28 1934

20. UNDERTAKER P. D. Heusser & Co ADDRESS Oran Mo

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 Scott
Township.....
City..... (No.....)

Registration District No. 820

Primary Registration District No. 4496

File No. 11568
Registered No.....
St..... Ward.....

2. FULL NAME

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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. 61 1 9

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 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March, 26, 1934

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19

I last saw him alive on 19 Death is said

to have occurred on the date stated above, at 19

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

acute dilatation of heart. Date of onset

Leg amputated results of an infection.

Other contributory causes of importance: injury and active life

Leg was amputated about two years prior to death.

Name of operator 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)

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