

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

Do not use this space.

MAY 25 1934

1. PLACE OF DEATH

County Cass
Township Pecunia
City _____ (No. _____)

Registration District No. 156
Primary Registration District No. 5220

File No. 12177
Registered No. 28 St. _____ Ward _____

2. FULL NAME Samuel W. Adams

(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

1. MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Usual place of abode)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3, 1934

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Don't know

22. I HEREBY CERTIFY, That I attended deceased from April 1, 1934, to April 3, 1934.
I last saw him alive on April 3, 1934. Death is said to have occurred on the date stated above, at 7 P. m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 30-1849

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

7. AGE YEARS 84 MONTHS 8 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

Cerebral apoplexy
Date of onset _____

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

Other contributory causes of importance: Stroke

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

13. NAME ? Non-Know. Adams.

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) John A. Adams, Lisle, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Orendy Cemetery DATE 4/4, 1934

19. UNDERTAKER (ADDRESS) Wagnerburgers, Harrisonville, Mo.

20. FILED 4/5, 1934 W. B. Long Registrar

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) E. M. Greffier, M. D.
(Address) Orendy, Cass, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MOTHER FATHER

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MOTHER FATHER

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