

SEP 12 1934

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

Do not use this space.

1. PLACE OF DEATH

County AndrainRegistration District No. 24Township PrairiePrimary Registration District No. 5-0 3 3

City

(No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)Widowed5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OFWilliam H Adams

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

September 15-1958

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.751026

OCCUPATION

8. Trade, profession, or particular
kind of work done, as spinner,
sawyer, bookkeeper, etc.Housewife9. 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 12212. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Newton Ill

FATHER

13. NAME

J. J. Cramer14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Ill

MOTHER

15. MAIDEN NAME

Jared16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)Ill17. INFORMANT
(ADDRESS)Mrs. J. H. Hammermeyer

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Becher Cemetery Andrain Co Mo

DATE

August 14, 193419. UNDERTAKER
(ADDRESS)Myrders & Hauger

20. FILED

8-131934W. H. McCall

Registrar

MEDICAL CERTIFICATE OF DEATH

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

Aug-11 193422. I HEREBY CERTIFY, That I attended deceased from
May 10, 1934 to July 12, 1934I last saw her alive on July 11, 1934 Death is saidto have occurred on the date stated above, at 12 A. M.

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

Chronic ulcerative colitis - Mechanical obstruction of bowel due to fibroid tumor of uterus.

Date of onset

Other contributory causes of importance:

Name of operation Physician's exam Date of noWhat test confirmed diagnosis? Physician's exam 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 no, 1934Where did injury occur? no (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury noNature of injury no24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) R. H. Van Hyndersden, M. D.(Address) Meriden, Mo.

1939

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Sarah L. Adams
 Who died at _____ on Aug 11 - 1934
 Residence: No. _____ St. _____
 (If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
 Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 75 Months 10 Days 26

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Chronic Ulcerative Colitis - mechanical
 Date deceased last worked at this occupation: Month _____ Year _____
 Birthplace (State or country) obstruction of bowel due to fibroid tumor of uterus, not malignant
 Birthplace of father (State or country) _____
 Birthplace of mother (State or country) _____
 Principal cause of death: _____

Other contributory causes of importance _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 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 _____
 Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 Name of physician _____
 Address of physician _____

X Signature of Registrar W. H. McCall Registrar Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. N. 24

Very truly yours,

Primary Reg. Dist. N. 5033

E. J. Mc Gough md
ge

Special Agent.

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