

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**

Do not use this space.

5.30
JAN 14 1935

42030

1. PLACE OF DEATH

County Dickinson
Township St. Joseph Mo.
City St. Joseph Mo. (No. State Hospital No. 2.)

Registration District No. 85
Primary Registration District No. 1001
State Hospital No. 2.

File No. _____
Registered No. 1364
State _____ Ward _____

2. FULL NAME

(a) Residence, No. Brenton Mo. 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) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 3, 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 1 10

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 83

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 12 3/4

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Allerton Ia

13. NAME John Adams

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

15. MAIDEN NAME Sarah Jenks

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Lukenn

17. INFORMANT (ADDRESS) State Hospital Records St. Joseph Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Albuquerque, N. M. DATE Dec. 19, 1934

19. UNDERTAKER (ADDRESS) H. G. Sidentaden 1802 Union St. St. Joseph, Mo.

20. FILED 12-14-1934 John L. Bender Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 12, 1934

22. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1926 to Dec 13, 1934

I last saw him alive on Dec 13, 1934. Death is said to have occurred on the date stated above, at 10:30 a.m.

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

General Paralysis of Insane
over 3 1/2

Other contributory causes of importance:

Curiousity with acetate 11/1/34

Name of operation None Date of _____

What test confirmed diagnosis? _____ 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) J. Miller, M. D.

(Address) State Hosp No 2

