

MAY 25 1935

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

Do not use this space.

11796

1. PLACE OF DEATH

County Adair

Registration District No. 4

File No. _____

Township _____

Primary Registration District No. 3001

Registered No. 80

City Kirksville (No. _____)

St. _____ Ward _____

2. FULL NAME Mal. Adams

(a) Residence, No. 408 N. Main St. 2 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX FF 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-22-1935

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

22. I HEREBY CERTIFY, That I attended deceased from 2-22-1935 to 4-22-1935

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-13-1878

I last saw him alive on 4-22-35, 1935. Death is said to have occurred on the date stated above, at 10:30 a.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 57 0 9

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

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

Hypertrophy of heart
Chronic myocarditis

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: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hedrick Iowa

13. NAME Jacob Amstbaugh

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1935

15. MAIDEN NAME Mary Alice Gray

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) we know

17. INFORMANT (ADDRESS) J. M. Adams, 408 N. Main St. Kirksville

Manner of injury _____ Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland Park DATE 4-25- 1935

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

19. UNDERTAKER (ADDRESS) Dec Riley, Kirksville Mo.

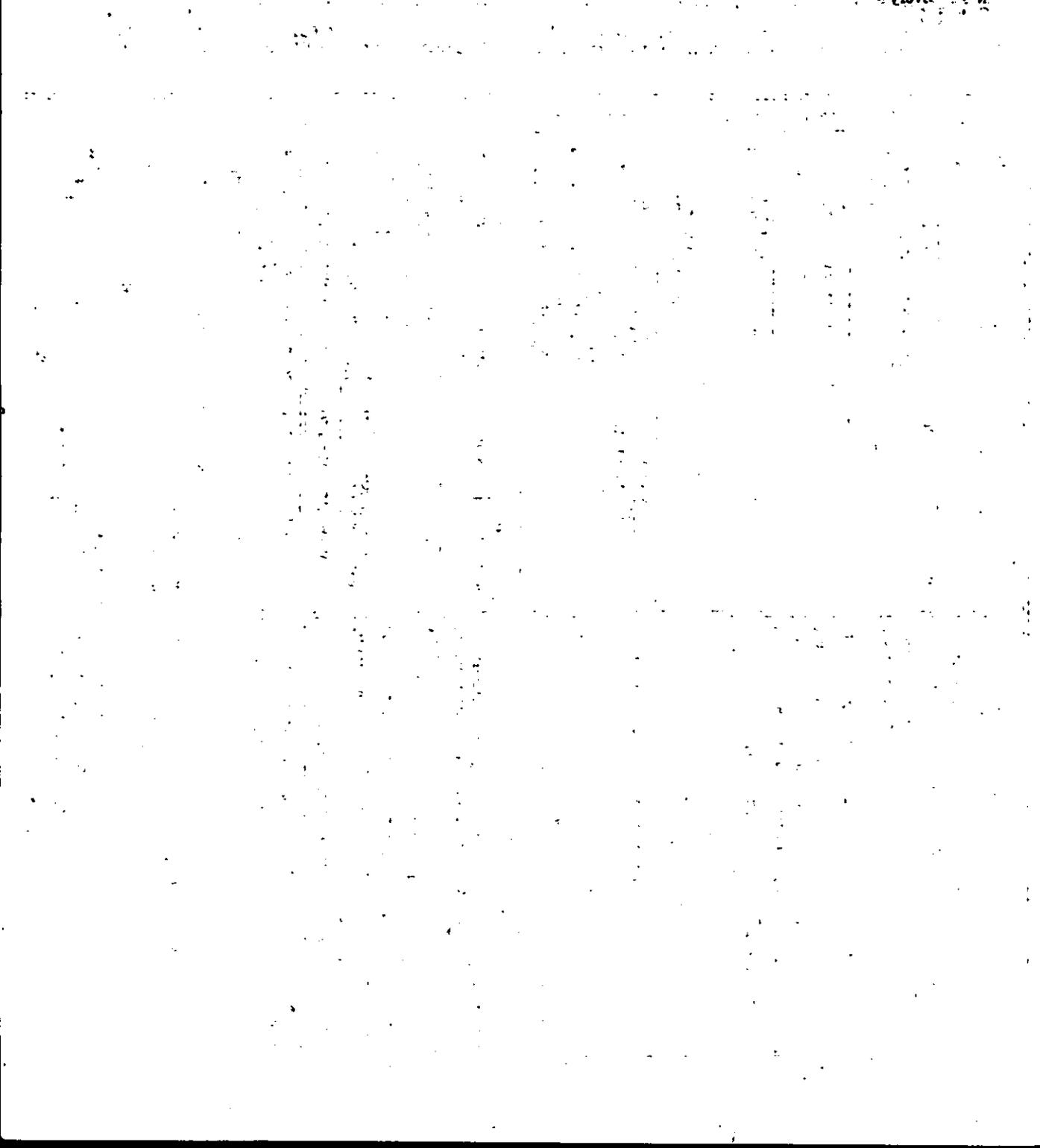
(Signed) F. B. Farrington, M. D.
(Address) Kirksville, Mo.

20. FILED April 27 1935

Registrar.

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 Adair Registration District No. 4
 Township..... Primary Registration District No. 3001
 City..... (No.) St. Ward)

File No.
 Registered No. 80

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 F 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, hr. or min.

OCCUPATION

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

MOTHER FATHER

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 Apr 29 35 Spencer Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 22 1935

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

I last saw him/her 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: 930

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).....

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