

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

Do not use this space.

36781

1. PLACE OF DEATH ^{Dec 19 1935} *Montgomery*
 County *Montgomery* Registration District No. *595*
 Township *Upper South* Primary Registration District No. *5791*
 City (No. St. Ward)

2. FULL NAME *Ellen, Frances 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 *1 yrs. 6 mos.* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. *20*
 Registered No. *B.P.*

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widow*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Jim Adams*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 7th 1853*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 4 27
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House wife*
 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 *—*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *NOV 4 1935*
 22. I HEREBY CERTIFY That I attended deceased from *June 24*, to *Nov 4*, 1935
 I last saw her alive on *Nov 3*, 1935. Death is said to have occurred on the date stated above, at *2 P.* m.
 The principal cause of death and related causes of importance were as follows:
Hemiplegia Date of onset *Oct*
Cerebral Hemorrhage *20-*
— *35*
 Other contributory causes of importance:
Chronic Interstitial Nephritis? *yes*
 Name of operation *—* Date of *—*
 What test confirmed diagnosis *Physical* 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? *no*
 If so, specify *—*
 (Signed) *A. A. Manserch* M.D.
 (Address) *Wallerilla Mo*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Maryland*
 FATHER 13. NAME *Henry Reed*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Maryland*
 MOTHER 15. MAIDEN NAME *Elizabeth Turner*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Maryland*
 17. INFORMANT *Leta Bourne*
 (ADDRESS) *Wallerilla, Mo.*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Middlebury Mo* DATE *Nov. 5 1935*
 19. UNDERTAKER *F. W. Hubbs*
 (ADDRESS) *Wallerilla Mo*
 20. FILED *Nov 5 1935* *Miss Mike McBurnett*
 Registrar.

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.

RECORD WITH ORIGINAL INFORMATION—THIS IS A PERMANENT RECORD

