

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

1662
Do not use this space.

1. PLACE OF DEATH
(a) County Boone Registration District No. 73
(b) Township Columbia Primary Registration District No. 5112 Registered No. 2
(c) City _____ (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Joseph S. Adair
(a) Residence, No. Boone Co. Mo. ☐ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Ella Adair</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>11-16-1852</u>		
7. AGE <u>87</u>	YEARS <u>1</u>	MONTHS <u>18</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
11. Total time (years) spent in this occupation		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Callaway Co. Missouri</u>		
FATHER	13. NAME <u>Joseph Adair</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
MOTHER	15. MAIDEN NAME <u>Don't Know</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>" "</u>	
17. INFORMANT (ADDRESS) <u>Ben Adair</u> <u>Fulton, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Millersburg Cemetery</u> <u>1-7-</u> <u>#20</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Parkers</u> <u>Columbia, Mo.</u>		
20. FILED <u>1/6/</u> <u>1940</u> <u>Allie Selby</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-4 1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 1-____, 1940

I last saw him alive on 11-21, 1938 Death is said to have occurred on the date stated above, at 7:30 a.m.

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

Date of onset 1934

Other contributory causes of importance:
Arterio Sclerosis
Do not know

Name of operation None Date of _____

What test confirmed diagnosis? None 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 _____, 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 None

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. D. Lyon M. D.
(Address) Columbia, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3893

P. O. Address Columbus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.