

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

Do not use this space.

1. PLACE OF DEATH

County Wright Registration District No. 352
Township Wright Primary Registration District No. 4209
City Marion (No. 10133)

File No. 32626
Registered No. 11
St. _____ Ward _____

2. FULL NAME

W W Adamson
(a) Residence, No. Montrose Mo St., _____ Ward. _____
(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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct-18-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 11 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retail Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Bate, MO
(STATE OR COUNTRY)

10. NAME OF FATHER Wm Adamson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Fran J Arbuckle

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT Miss Rize Adamsen
(Address) Montrose Mo

15. FILED 9.17.1934 J M Miller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sep. 15 1934
17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1934 to Sep 15 1934, that I last saw him alive on Sep 15 1934, and that death occurred, on the date stated above, at 10:30 a m.

THE CAUSE OF DEATHS WAS AS FOLLOWS:
Uræmia chronic hepatitis
atheroma
hepatitis (duration) 1 yrs. 6 mo. 30 ds.
CONTRIBUTORY atheroma
(SECONDARY) 97 (duration) _____ yrs. _____ mos. _____ ds.

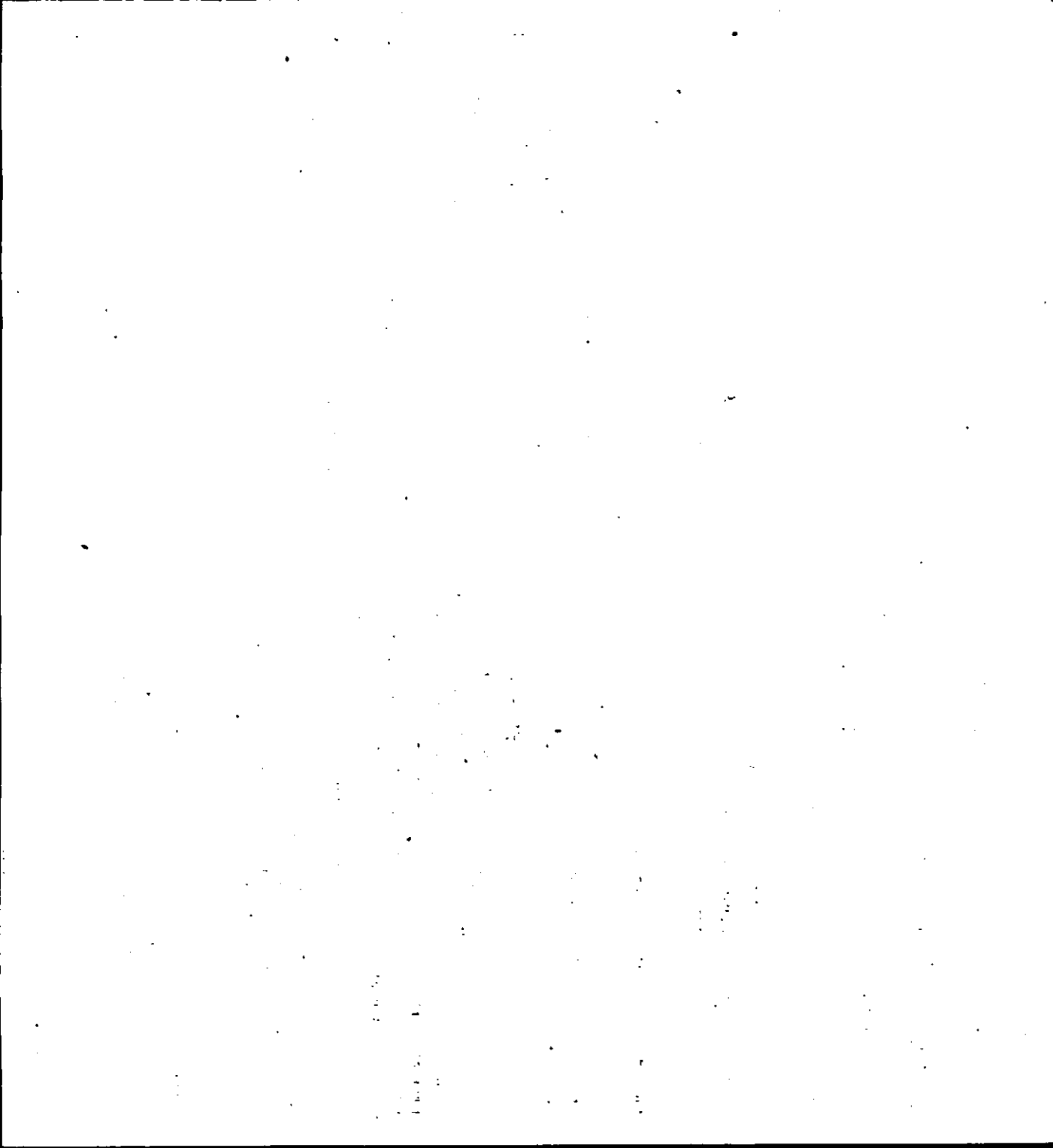
18. WHERE WAS DISEASE CONTRACTED 1255
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) J M Miller, M. D.
(Address) Montrose Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Montrose Cemetery DATE OF BURIAL 9/17 1934

20. UNDERTAKER J Remmety ADDRESS Montrose Mo

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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Henry
Township _____
City _____ (No. _____ St. _____ Ward)

Registration District No. 352
Primary Registration District No. 5493

File No. _____
Registered No. 11

2. FULL NAME

W.W. Admison

(a) Residence, No. _____ St. _____ Ward. _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) w

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 18 - 1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 11 9

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 _____

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 Dec 6 1934 J. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 15 1934

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____. I last saw him _____ 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:

Unruptured Chr. cystitis
adhesions
Arterial due to
Septic cystitis
Date of onset _____

Other contributory causes of importance: _____

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) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

S-32626