

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

Do not use this space.

14148

1
2
6
2

24 1929

1. PLACE OF DEATH

County Chariton
Township _____
City Salisbury (No. _____) St. _____ Ward _____

Registration District No. 175
Primary Registration District No. 4104

File No. _____
Registered No. 23
St. _____ Ward _____

2. FULL NAME Elizabeth M^e Adams

(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 9 MEDICAL CERTIFICATE OF DEATH

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Black</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u> ✓
-------------------------	----------------------------------	------------------------------------------------------------------------

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-20 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1927, to 4-20 1929 that I last saw h. alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage into abdominal cavity

460 (duration) yrs. mos. ds.
CONTRIBUTORY Tumor of bleeding (SECONDARY)
colon 55E (duration) yrs. mos. ds.
103B

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Prof. W. J. Allen, M.D.
4/20, 1929 (Address)

*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 Salisbury Cemetery DATE OF BURIAL 4-22 1929

20. UNDERTAKER Winkelmeier Bros ADDRESS Salisbury Mo

282
31
31

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>about 60</u>				

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo

10. NAME OF FATHER Unknown

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

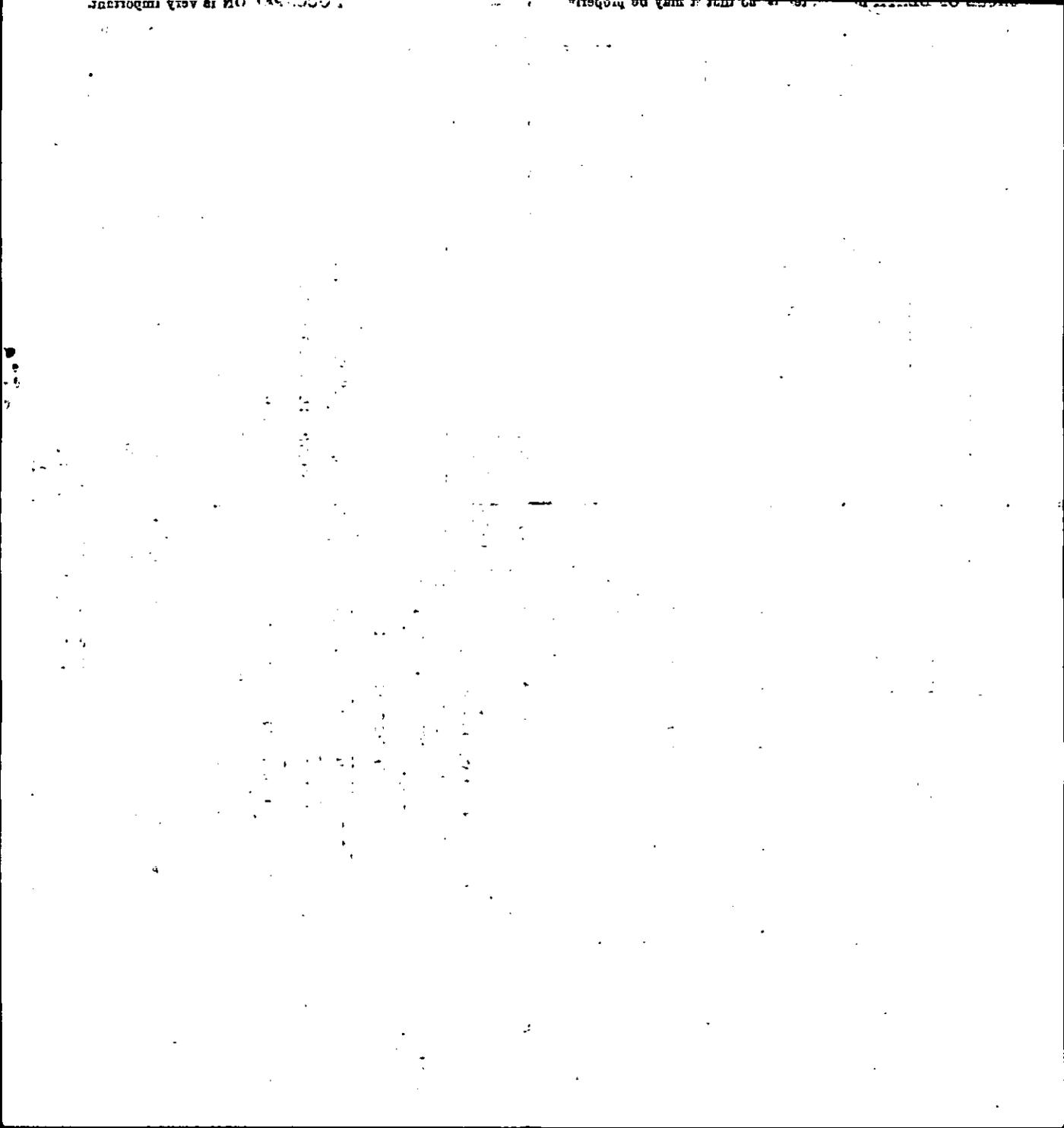
12. MAIDEN NAME OF MOTHER Miss Unknown (Address) 4/20, 1929

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

14. INFORMANT B. M^e Adams (Address) Salisbury Mo

15. FILED Apr. 1929 Gus Karfins REGISTRAR

PARENTS



**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 Chariton Registration District No. 175- File No. _____
 Township _____ Primary Registration District No. 4104 Registered No. 23
 City Walisbury (No. _____) St. _____ Ward _____

2. FULL NAME

Elizabeth McDona
 (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 Col 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, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY)

14. INFORMANT _____ (Address)

15. FILED 9/11, 1929 Gustawski REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/20 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) _____ yrs. mos. ds.
 CONTRIBUTORY tumor of descending colon (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at St. Bernard

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ (DATE)

WAS THERE AN AUTOPSY? 45

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Ralph J. Allen, M. D.

4/11, 1929 (Address)

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

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

Exact statement of OCCUPATION in plain terms, as property measured.

SUPPLEMENTARY

1000

THE FEDERAL BUREAU OF INVESTIGATION

Department of Justice

Washington, D. C.

4-11-68

MEMORANDUM

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 4-11-68

S-14148

RE: [Illegible]

DATE: 4-11-68

BY: [Illegible]

BY: [Illegible]

BY: [Illegible]

BY: [Illegible]

BY: [Illegible]

APPROVED AND FORWARDED: [Illegible]

SPECIAL AGENT IN CHARGE

[Illegible]

APPROVED AND FORWARDED: [Illegible]

SPECIAL AGENT IN CHARGE

[Illegible]

[Illegible]