

MAY 2

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

Do not use this space.

## 1. PLACE OF DEATH

County.....  
Township.....  
City.....

Registration District No. **791**  
**1003**

Primary Registration District No. **N. Sarah**

File No. **14442**  
Registered No. **3616**  
St. .... Ward)

## 2. FULL NAME

(a) Residence, No. **1046 N. Sarah** St., ..... Ward.

(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

## 2 MEDICAL CERTIFICATE OF DEATH

## 3. SEX

Male

## 4. COLOR OR RACE

Negro

## 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

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

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

8-8-1931

## 7. AGE

2

## YEARS

8

## MONTHS

1

## DAYS

If LESS than 1 day, ..... hrs. or ..... min.

## OCCUPATION

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

Child

## 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)

St. Louis mo

## FATHER

## 13. NAME

Steve Adams

## 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

La

## MOTHER

## 15. MAIDEN NAME

Gertrude Adams

## 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Mississippi

## 17. INFORMANT (ADDRESS)

Stephen Adams  
1046 N. Sarah

## 18. BURIAL, CREMATION, OR REMOVAL

## PLACE

GREENWOOD CEM.

## DATE

4/18

1934

## 19. UNDERTAKER (ADDRESS)

J. Russell and Co  
532 E. 1st

## 20. FILED

MAY 11 1934

J. J. Brebeck

Registrar.

## 21. DATE OF DEATH (MONTH, DAY, AND YEAR)

APR. 9 1934

## 22. I HEREBY CERTIFY, That I attended deceased from

APR. 6 1934 to APR. 9 1934

I last saw him alive on APR. 9 1934 Death is said to have occurred on the date stated above, at 11 a.m.

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

*Brancho-pneumonia*  
10/4/10

*H. M.*

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.....

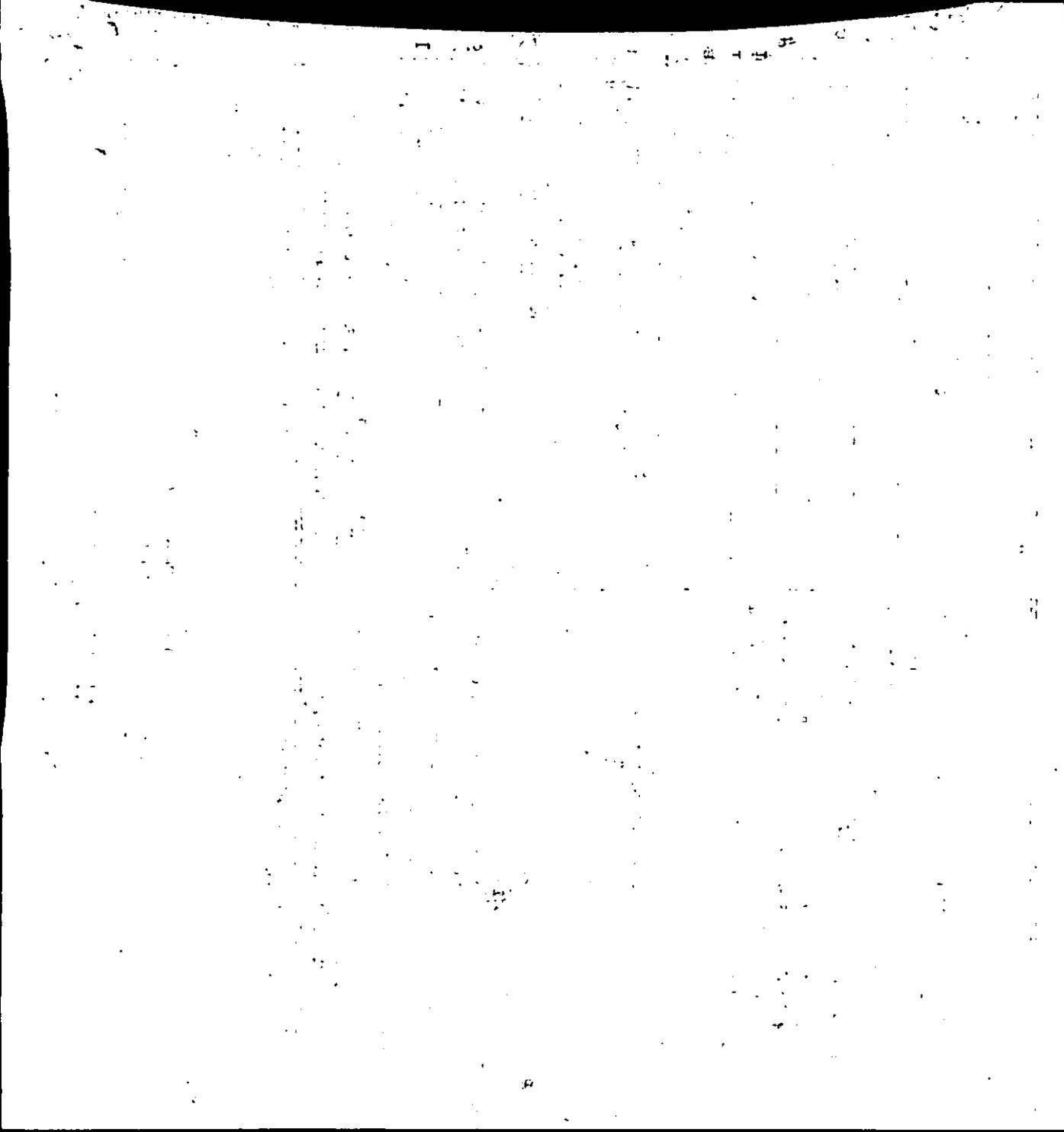
24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify.....

(Signed) *E. H. Hill* M. D.

(Address) *1105 N. Sarah*

CAUTION - THIS IS A PRELIMINARY STATEMENT OF OCCASIONAL DEATHS - IMPORTANT



14442

3616

St. Louis City

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Carl Adams  
Who died at \_\_\_\_\_ on Apr 9 - 1934  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex m Color or race B Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years 2 Months 8 Days 1

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

Date deceased, last worked at this occupation: Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: Broncho pneumonia  
Secondary to malaria

Other contributory causes of importance \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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 \_\_\_\_\_

Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

Name of physician Wm. E. Hill

Address of physician 1105 N. Sarah

Signature of Registrar J. F. Dedrick 4-5-34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,  
E. T. McGaugh M.D.

Reg. Dist. No. 791  
Primary Reg. Dist. No. 1003

Special Agent.

S-14442

1954

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