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

Do not use this space.

1. PLACE OF DEATH

County _Ray_
Township _Fishing River_
City _____ (No. _____)

Registration District No. _743_
Primary Registration District No. _6237_

File No. _35-339-a_
Registered No. _79_
St. _____ Ward)

2. FULL NAME _Cain Adams_

(a) Residence, No. _5 mi North East Ex. Spgs_ Ward.
(Usual place of abode)
Length of residence in city or town where death occurred _74_ yrs. mos. ds.
(If nonresident, give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _May 3-1861_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ......min.
	74	4	18	

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _X_

10. Date deceased last worked at this occupation (month and year) _Sept 20 1936_

11. Total time (years) spent in this occupation _all life_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _Kansas_

13. NAME _Thomas Adms_ (FATHER)

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

15. MAIDEN NAME _Unknown_ (MOTHER)

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

17. INFORMANT _Sarah Adams_ (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE _Rayville Mo_ DATE _Sept 22 1936_

19. UNDERTAKER _Herbert Hope_ (ADDRESS) _Excelsior Spng Mo_

20. FILED _1/10_ 1937 _____ Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _1:30 Am Sep 21 1936_

22. I HEREBY CERTIFY, That I attended deceased from _Jan 15_, 1936, to _July 25_, 1936
I last saw h__ alive on _July 25_, 1936 Death is said to have occurred on the date stated above, at _1:30_ m.
The principal cause of death and related causes of importance were as follows:

Apoplexy Date of onset _9-20-36_

Other contributory causes of importance:

Gen Arterio Sclerosis _3843_

Name of operation _na_ 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) _____ , M.D.
(Address) _Excelsior Spng, Mo._