

## STATE OF KANSAS

## STANDARD

State Board of Health—Division of Vital Statistics

## CERTIFICATE OF DEATH

Do not write

8

1798

in this space

1 PLACE OF DEATH: County Butler  
 Township Lawrence Registered No. 134  
 or City Salina Rural No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2 FULL NAME Asian Adair  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 (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.

## 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 Louise Spence (or) WIFE of \_\_\_\_\_  
 6 DATE OF BIRTH (month, day, and year) Sept 7 - 1942  
 7 AGE Years 26 Months 11 Days 22 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8 OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9 BIRTHPLACE (city or town) Pa  
 (State or country) Georgia

10 NAME OF FATHER William B. Adair

11 BIRTHPLACE OF FATHER (city or town) New York  
 (State or country) \_\_\_\_\_

12 MAIDEN NAME OF MOTHER Ruth McMichael

13 BIRTHPLACE OF MOTHER (city or town) Pa  
 (State or country) \_\_\_\_\_

14 Informant Leona Adair  
 (Address) 219 Grandview

15 Filed 10/16/19 E. G. Taylor Registrar

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1919

17 I HEREBY CERTIFY, That I attended deceased from July, 1918, to Sept 19, 1919, that I last saw him alive on Sept 19, 1919, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH \* was as follows:  
Arteriosclerosis  
 (duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. mos. ds.

18 Where was disease contracted if not at place of death? \_\_\_\_\_

Did an operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Anna Perkins M. D.  
 19 (Address) 219 Grandview St.

\* 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. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Townsend Cemetery Sept 27 1919

20 UNDERTAKER W. Turner ADDRESS Albion