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

6996

PLACE OF DEATH

County Knox

Township W Lyon

or Village Hurdland

or City (NO. St.; Ward)

Registration District No. 443 File No. 4

Primary Registration District No. 5601 B Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME *AMANDA BEERS*

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: January 23, 1850 (Month) (Day) (Year)

AGE: 65 yrs. 11 mos. 19 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ——

BIRTHPLACE (City or town, State or foreign country): Indiana

PARENTS

NAME OF FATHER: Kinnmann

BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

MAIDEN NAME OF MOTHER: Not Known

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Beers

(ADDRESS) Hurdland Mo.

Filed Feb 10, 1916. B F Humphrey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 3 Jan 12, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 11, 1916, to Jan 12, 1916,

that I last saw her alive on Jan 12, 1916,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cardiac, uremic asthma

93 D

1538

40

(Duration) 1/2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Asthma

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A D Gay, M. D.

Jan 14, 1916 (Address) Hurdland Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Park Cem

DATE OF BURIAL: 1-14, 1916

UNDERTAKER: R W Magruder

ADDRESS: Hurdland

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.

PLACE OF DEATH

County_____

Township _____
or
Village_____
or
City _____ (NO._____, _____ St.:_____ Ward)

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

ORD OF

Registration District No._____ File No._____ PLACE OF D

Primary Registration District No._____ Registered No._____

[If death occurred in a hospital or institution give its NAME instead of street and number] .....

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1_____
(Month) (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day,_____hrs. or_____min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____. _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ ceased.....

_____, *191*____ .....Color
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____ ied, Widowed o

that I last saw h_____ alive on _____, 191____

and that death occurred, on the date stated above, at_____ m.h.....

The CAUSE OF DEATH* was as follows:

Mont

Years

_____

_____

_____

_____(Duration)_____yrs._____mos._____ds. or town, State o

Contributory _____ther.....
(SECONDARY)

_____(Duration)_____yrs._____mos._____ds. f Father.....
or town, State o

(Signed)_____ M. D. e of Mother.....

_____, 191____ (Address)_____ f Mother.....
or town, State o

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

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LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

Mont

At place of death_____yrs._____mos._____ds. In the State_____yrs._____mos._____ds.

Where was disease contracted if not at place of death? _____

Former or usual residence_____ ath.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

y Cause.....
ending physici
ial or removal...
dertaker.....
ial.....