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

Do not use this space. 6093

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis Mo. (No. 3609a So. Broadway St. ..... Ward)

File No. .....

Registered No. 1266

2. FULL NAME Amanda E. Eggers

(a) Residence. No. 3609a So. Broadway St., 24 Ward. (If nonresident give city or town and State)
(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: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 4-1898

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
28	4	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(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.

PARENTS

10. NAME OF FATHER Edw. L. Green

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

12. MAIDEN NAME OF MOTHER Nora A. Webb

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

14. INFORMANT Edwin W. Eggers
(Address) 3609a So. Broadway

15. FILED FEB 5 1927 19.. Max C. Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 3 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Feby 2nd, 1927, to Feby 3, 1927, that I last saw her alive on Feby 3, 1927, and that death occurred, on the date stated above, at 5:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Post-Partum Hemorrhage

144 F

142 C 144 B

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Parturition

..... (duration) ..... yrs. ..... mos. 1 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? .....

2/4 (Signed) W. C. Owen, M. D
, 1927 (Address) 3833 Folsom

*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: Wright City Mo.

DATE OF BURIAL: Feb. 6 - 1927.

20. UNDERTAKER: Ziegenhein Bros.

ADDRESS: 2623 Cherokee

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.