

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

Do not use this space.

28545

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis, Mo.** (No. **1410 S. Broadway**)..... St. Ward)

File No.
 Registered No. **18076**
 St. Ward)

2. FULL NAME Amanda Fritz

(a) Residence. No. 1410 S. Broadway..... St. 23 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** WIDOW
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 28, 1958

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 6 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... Illinois
 (STATE OR COUNTRY)

10. NAME OF FATHER Jess Cooper

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Louise Miller
 (Address) 1410 S. Broadway

15. FILED SEP 12 1927 W. C. Hinkley
 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 10th 27

17. I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1925, to Sept 8, 1927 that I last saw him alive on Sept 8, 1927, and that death occurred, on the date stated above, at 7:05 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy (Cerebral haemorrhage)

CONTRIBUTORY (SECONDARY) 7401 (duration) 1 yrs. 9 mos. - da.

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) J. Blank, M. D.
Sept. 10, 1927 (Address) 1348 Chouteau Ave.

*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 Calvary **DATE OF BURIAL** Sept. 12, 1927

20. UNDERTAKER Wacker-Heldrich **ADDRESS** 2331 S. Broadway

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.

L. H. Brown
1323 S. Bradley