

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

Do not use this space.

32635

1. PLACE OF DEATH

County Andrew

Registration District No. B 4010

Township Savannah

Primary Registration District No. 4010

City Savannah

File No. 77

Registered No. 77

2. FULL NAME

Amanda Townsend

(a) Residence No. _____ St. _____ 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F

4. COLOR OR RACE

W

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

W

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF Jonathan Townsend

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

Feb 28 1839

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>89</u>	<u>7</u>	<u>12</u>	

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)

No Record

(STATE OR COUNTRY)

Indiana

10. NAME OF FATHER

William Parker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

No Record

(STATE OR COUNTRY)

No Record

12. MAIDEN-NAME OF MOTHER

Miriam Hacker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

No Record

(STATE OR COUNTRY)

No record

14.

INFORMANT

James F. Gee

(Address)

2623 Butler Ave. Savannah

15.

FILED

Oct 11 28

W. J. Johnson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct. 10 - 1928

17.

HEREBY CERTIFY That I attended deceased from Sept 25 28 to Oct 10 1928 that I last saw her alive on Oct 10 and that death occurred, on the date stated above, at 7:05 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Hypostatic Pneumonia
1810A
1947

!!! B (duration) 7 yrs. 7 mos. 7 ds.
CONTRIBUTORY Tracheitis
(SECONDARY) (duration) 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) X Ray
10/10/28 (Address) Savannah Ga

*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

DATE OF BURIAL

Savannah Ga

12th 1928

20. UNDERTAKER

ADDRESS

E. C. Breit Savannah

Every item of information should be properly classified and the CAUSE OF DEATH in plain terms, so that it may be properly classified.

1928

6

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Madison
Township Savannah
City Savannah (No.) St. Ward)

Registration District No. 13
Primary Registration District No. 4070

File No.
Registered No.

2. FULL NAME

(a) Residence. No. St. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W (write the word)

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

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

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

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT

(Address)

FILED

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 - 19 28

17.

I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

that I last saw h. alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

hypostatic pneumonia

CONTRIBUTORY (SECONDARY)

Fractured femur
caused by fall

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF

185 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

SUPPLEMENTARY

S-32635