

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

Do not use this space.

5525

1. PLACE OF DEATH

County.....Buchanan.....

Registration District No.....

Township.....

Primary Registration District No.....1001.....

City.....St. Joseph.....

(No. Mo. Methodist Hospital).....

File No.....

Registered No.....190.....

St. Ward)

2. FULL NAME Amanda Jane Nash

(a) Residence. No. Gower Mo. St. Ward. Gower Mo.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 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 Thomas Nash.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1, 1862

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	66	9	13	

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) Gower
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wm. Adams

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

12. MAIDEN NAME OF MOTHER Sally Brockman

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

14. INFORMANT Thomas Nash
(Address) Gower Mo.

15. FILED..... 19.....
John G. [Signature]
REGISTRAR

85

1001

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 14 19 29

17. I HEREBY CERTIFY, That I attended deceased from 2/12/29 to 2/14/29 19.....
that I last saw h. GT. alive on 2/14/29 19....., and that death occurred, on the date stated above, at 8 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Right Hy dro Pyo nephrosis
133A
133C (duration) 27 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Acute suppression of mind post operative (duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH..... DATE OF 2/12/29
WAS THERE AN AUTOPSY..... not

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed)..... [Signature] M. D.
Feb. 14 19 29 (Address) St. Joseph Mo.

*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 Gower Mo. DATE OF BURIAL Feb. 16 19 29

20. UNDERTAKER H. O. Sidenfaden ADDRESS 1802 Union St.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

21 1929

23

1
2

31

FEB 14 1929

