

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

Do not use this space.

12391

791
1003

File No. _____
Registered No. 2911
St. _____ Ward _____

1. PLACE OF DEATH

County..... Registration District No.....
Towship..... Primary Registration District No.....
City St. Louis (No. 3012 & Bailey)

2. FULL NAME Amanda Schuur

(a) Residence. No. 3012 & Bailey St., 10 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White Married

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

Fred Schuur

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 26, 1884

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 | 7 | 9 | _____

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) St. Louis (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Charles Wells

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Fred Schuur (Address) 3012 & Bailey

15. FILED 6 1929 May 2 Franklin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5 1929

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to March 5, 1929 that I last saw her alive on March 5, 1929, and that death occurred, on the date stated above, at 11:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute myocarditis

CONTRIBUTORY Rheumatoid arthritis (SECONDARY)

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) S. Ellick, M. D.

*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 St. Peters Cem DATE OF BURIAL Mar 8 1929

20. UNDERTAKER Ston & Wells ADDRESS 2907 N Grand

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.

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