

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

Do not use this space.

13844

23 1090

PLACE OF DEATH

County Boone
Township _____
City Columbia (No. _____)

Registration District No. 7.3
Primary Registration District No. 3006

File No. 115
Registered No. _____
St. _____ Ward _____

2. FULL NAME Amanda Carter

(a) Residence. No. 405 E. Ash 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. 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 Colored widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
50 Don't know

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Callaway Co
(STATE OR COUNTRY)

10. NAME OF FATHER Do know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

12. MAIDEN NAME OF MOTHER Callie Roberts

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

14. INFORMANT (Address) Dr. Miller Medical Ton Columbia Mo.

15. FILED 4-29-29 Beatrice Greaber REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-26 19 29

17. I HEREBY CERTIFY, That I attended deceased from 4-22- _____, 1929, to Apr - 26, 1929, that I last saw him alive on Apr - 26, 1929, and that death occurred, on the date stated above, at 9:40 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY)

75W

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physic

(Signed) J. A. Taylor, M. D.

4-29-1929 (Address) 116 S - 28th

*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 Cemetery Columbia 4-29 1929

20. UNDERTAKER

A. C. Freeman Columbia Mo

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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