

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph (No. St. Joseph Hospital) St. _____ Ward _____

33035

File No. _____
 Registered No. 1190

2. FULL NAME Ardelma Amos

(a) Residence. No. 1517 south 11 street 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 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 George J. Amos

6. DATE OF BIRTH (MONTH, DAY AND YEAR) December 21, 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>37</u>	<u>9</u>	<u>24</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) Agency
 (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER James Roberts
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Missouri
 12. MAIDEN NAME OF MOTHER Nancy Mitchell
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Buchanan Co.
 (STATE OR COUNTRY) Missouri

14. INFORMANT Geo. Amos
 (Address) 1517 south 11 street

15. FILED 15 1929 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 15 19 29

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Oct 15, 1929.
 that I last saw him ST alive on _____, 19____, and that death occurred, on the date stated above, at 1-20 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Embolism
139c
 (duration) _____ yrs. _____ mos. _____ ds.
111A
 CONTRIBUTORY Suppurative Hysterectomy
 (SECONDARY) (duration) _____ yrs. _____ mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct 10 1924

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) Wm F. Cook, M. D.

Oct. 15 19 29 (Address) 1117 S. 11th St. 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 DATE OF BURIAL

Fragier No. Oct. 17 19 29

20. UNDERTAKER [Signature] ADDRESS 1802 Union St.

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.

