

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

Do not use this space.

41964

1. PLACE OF DEATH

County St. Louis
Township Central
City Welston, St. Louis (No. 2124 Cherry)

Registration District No. 789
Primary Registration District No. 6000

File No. _____
Registered No. 385
St. _____ Ward _____

2. FULL NAME Amanda Cole.

(a) Residence. No. 2124 Cherry St. 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 Charles Cole.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/8/1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 10 8

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) (STATE OR COUNTRY) Ohio.

10. NAME OF FATHER Henry Koder.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania.
12. MAIDEN NAME OF MOTHER Maria Mowar.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not Known.

14. INFORMANT A. E. Cole
(Address) 2124 Cherry St.

15. FILED 12/18 19 29 Rolla Bency, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/16/29 19 29

17. I HEREBY CERTIFY, That I attended deceased from 7/1/29 to Dec. 16, 1929 that I last saw her alive on Dec. 16, 1929 and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis
Age - senility
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds. 6 mos. 0 ds.
(duration) yrs. mos. ds. 6 mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH same

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. Davis, M. D.

12/17, 1929 (Address) 4924 Madison St.

*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

Valhalla Cemetery 12/20/29
20-UNDERTAKER ADDRESS 3710 N. Grand
Provooshudko

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.

David
Bidg 2-4
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