

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

Do not use this space.

32910

1. PLACE OF DEATH

County Jackson
Township Low
City K. C. Mo.

Registration District No. 399
Primary Registration District No. 1002
(No. Trinity Lutheran Hospital)

File No. _____
Registered No. 1138
St. _____ Ward _____

2. FULL NAME

Amelia Nordfeldt Frost

(a) Residence. No. 1440 Jarboe Ave St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9 - 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 8 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(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) Sweden

10. NAME OF FATHER no record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no record

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT J. J. Corrian
(Address) 1440 Jarboe Ave. K.C. Mo.

15. FILED 10/12 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 1930

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1927, to Oct 11, 1930 that I last saw her alive on Oct 15, 1930, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
18 L.H.
194 H.
82 H. (duration) yrs. mos. ds.
11. Int. Cap. Infection
CONTRIBUTORY (SECONDARY) 5 mo.
acc. fall (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Charles J. ... M. D.
Oct 11 1930 (Address) 1509 Park ...

*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 Elmwood DATE OF BURIAL Oct 13 1930

20. UNDERTAKER Mrs. E. L. Forster ADDRESS K. C. Mo.

This certificate is to be filed in the office of the registrar of vital statistics, who shall file it in the office of the health officer of the county in which the death occurred.

Mr. G. Wilmer Mear

Professional

4738 Oak

ap. Feb. 2nd

7:30 pm

Bureau of Vital Statistics,
City Hall,
City.

Gentlemen:

This fall was at home
by stepping off front step.

Very truly yours,

A handwritten signature in cursive script, appearing to read "Charles D. ...".

CWM:EG.

1930

S-32910

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City..... (No.....) St..... Ward.....

Registration District No. 399
Primary Registration District No. 1002

File No.....
Registered No. 4128

2. FULL NAME

Amelia Nordstedt Frost

(a) Residence. No..... St..... Ward.....
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

OCCUPATION OF DECEASED

Trade, profession, or kind of work
General nature of industry, establishment in (or employer)
Employer

OR TOWN

(CITY OR TOWN)

FATHER

PLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED

10/23/30 M. M. Crane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 11 19 30

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (that I last saw him..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

CONTRIBUTORY (SECONDARY) Capitulum fracture femur et: accidental fall (duration)..... yrs. mos. ds.

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)....., M. D.
, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state at what time of day the death occurred. OCCURRENCE OF DEATH should be stated. PHYSICIANS should state at what time of day the death occurred. OCCURRENCE OF DEATH should be stated.

THEY ARE COMPLETE AS

REGIS

SUPPLEMENTARY

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