

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.

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

Do not use this space.

APR 26 1935

9325

1. PLACE OF DEATH

County Jackson
Township Jackson
City Keosauqua

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1275 St. _____ Ward _____

2. FULL NAME

Minta T. G. Ampros

(a) Residence, No. 5311 Swape Parkway 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 25-1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>64</u>	<u>2</u>	<u>29</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

FATHER 13. NAME No Record

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME No Record

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT E. R. Wallack
(ADDRESS) 5311 Swape Parkway

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park, Keosauqua, Mo. DATE 3/26/35

19. UNDERTAKER Mrs. C. L. Foster
(ADDRESS) 918 Brooklyn Avenue

20. FILED 3-24-35 M. H. Crowe asst. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March - 24 - 1935

22. I HEREBY CERTIFY, That I attended deceased from March 20, 1935, to March 24, 1935
I last saw her alive on March 23, 1935. Death is said to have occurred on the date stated above, at 4:30 A.M.
The principal cause of death and related causes of importance were as follows:

Lobar pneumonia (Bilateral) Date of onset March 20, 1935

Other contributory causes of importance: None

Name of operation none Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Kenneth A. Davis, M. D.
(Address) 3301 Woodland
Keosauqua, Mo.

2805833

Office - 330 Woodland
will be at office at 2:00

ATTN: [illegible]

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