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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4351

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 1181

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Christian Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Owensville NR
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME 200 Amanda Fuchs

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James

6. (c) Age of husband or wife if alive 25 years

7. Birth date of deceased Feb. (Month) 20 (Day) 1909 (Year)

8. AGE: Years 30 Months 11 Days 13 If less than one day hr. min.

9. Birthplace Mt. Sterling (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Topel
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Henrietta Helle
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant James Fuchs
(b) Address Owensville, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/6/40 (Month) (Day) (Year)
(c) Place: burial or cremation Bay, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) FEB 5 1940 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 3
year 1940 hour 6 minute 06 A.M.

21. I hereby certify that I attended the deceased from Jan. 29, 1940, to Feb. 3, 1940, that I last saw her alive on Feb. 3, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Puerperal Sepsis — Duration 5 days

Due to Dystocia followed by attempted delivery

Due to Later Jan. 29 by cesarean section

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations Normal pregnancy

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature T. R. Ayers (M. D. or other)
Address 607 N. Grand Bl. Date signed 2-5-40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____ working under my personal supervision.

Signed Greg W Wilkinson

Licensed Embalmer No. 3575

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.