DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 35559

FILED DEC 3 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10317

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Infirmary 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 years (Specify whether
In this community 15 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 600
(c) City or town St. Louis 13/7
(If outside city or town limits, write "RURAL")
(d) Street No. 5800 Arsenal St. 9
(If rural, give location)
(e) Citizen of foreign country? American (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Amanda Livsey
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex female 1
5. Color or race white
6. (a) Single, widowed, married, divorced widow 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 3, 1862 (Month) (Day) (Year)
8. AGE: Years 83 Months 8 Days 24 If less than one day hr. min.
9. Birthplace Alabama 1 (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name Jeff. Kinney
13. Birthplace Ireland 4 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mary Jane Janna
15. Birthplace Ga. 1 (City, town, or county) (State or foreign country)
16. (a) Informant C. Hannon,
(b) Address 5800 Arsenal St.
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 11-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director W. Richter
(b) Address 3500 Ratgeb
19. (a) NOV 28 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27 year 1945 hour 4 a.m. minute M.
21. I hereby certify that I attended the deceased from July 2, 1945 11-27-45, 19, to Nov 27, 1945; that I last saw her alive on 11-26-45, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Hypertensive Heart disease	1945 plus
Due to Generalized arteriosclerosis	1944 plus
Due to	
Other conditions (Include pregnancy within 3 months of death)	

93

Major findings:
Of operations
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 Palmer Prussen Bowdish (M. D. or other)
Address CITY INFIRMARY Date signed 11-27-45

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10[illegible]

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10317

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Amanda Livsey

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 3 (Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 2 If less than one day hr. min.

9. Birthplace (City, town, or county) Alabama (State or foreign country)

10. Usual occupation Nil

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) JAN 17 1940 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 27 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

35559