S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 4 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

28988
State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8110

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 3515 Halliday Ave. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 3515 Halliday Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Amanda Drier
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 Widow
6. (b) Name of husband or wife Fred W. Drier
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 7 (Day) 1865 (Year)

8. AGE: Years	Months	Days	If less than one day
81	9	19	hr. min.

9. Birthplace Salem (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
12. Name Jim Hobson (Father)
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown (Mother)
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Bessie McDowell
(b) Address 3515 Halliday
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olive, Ill.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) (Date received local registrar) (b) (Registrar's signature)

AUG 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26 year 1947 hour 5 minute 45 A.M.
21. I hereby certify that I attended the deceased from Aug 23 1947, to Aug 26th 1947, that I last saw her alive on Aug 25th 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	10 hours
Due to Chronic hypertension, heart disease	6 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of 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 Earl H. Baker (M. D. or other)
Address 3353 Nebraska Ave. Date signed 8-26-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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

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.