OCT 26 1927

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

Do not use this space.
27028

1. PLACE OF DEATH

County: Harrison — Registration District No. 334 — File No. 402

Township: — Primary Registration District No. 197 — Registered No.

City: Bethany (No. ..... St. ..... Ward)

2. FULL NAME Eva Washington Foster

(a) Residence. No. ..... St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/9/1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	53	10	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) Richmond (STATE OR COUNTRY) Virginia

PARENTS

10. NAME OF FATHER Frank Hoylman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Mary Kinkade

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Wm Foster (Address) Bethany, Mo.

15. FILED 10/10 1927 W. J. Hamed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/18 1927

17. I HEREBY CERTIFY, That I attended deceased from ~~her~~ Sept 8, 1927, to Sept 18, 1927 that I last saw ~~her~~ alive on Sept 18, 1927, and that death occurred, on the date stated above, at 9 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis following ptomaine poisoning

177

129 (duration) 8 yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY) ..... (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) Eva Wood D.O., M.D.

9/26, 1927 (Address) Bethany, Mo.

*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: Miriam Cemetery — DATE OF BURIAL: 9/20 1927

20. UNDERTAKER: S W Sams — ADDRESS: Bethany Mo.

N. B.—Every item of information should be carefully supplied. Avoid abbreviations. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

B. B.—Every item of labor, etc.
CAUSE OF DEATH in plain terms so that

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 Harrison — Registration District No. 334 — File No. 402

Township ..... — Primary Registration District No. 4197 — Registered No. .....

City Bethany (No. ....., ... St. ..... Ward)

2. FULL NAME Eva Washington Foster

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 10/10, 1927 W J Hain Jr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-18 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis following Ptomaine Poisoning from Eating Hamburgh
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information [illegible] should state CAUSE OF DEATH in plain terms, so that it [illegible] is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

[illegible] THIS IS A PERMANENT RECORD