

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

Do not use this space.

34983

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **10130**
St. Ward)

2. FULL NAME

(a) Residence. No. **10231 N. Leffingwell St.** Ward. **21**
(Usual place of abode)

Length of residence in city or town where death occurred **6** yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** | 4. COLOR OR RACE **Col.** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 14, 1908**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 | 1 | 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... **Nil**
(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) **Tenn.**

10. NAME OF FATHER

Lindsay Foster

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) **Tenn.**

12. MAIDEN NAME OF MOTHER

Willie Mae Matthews

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) **Tenn.**

14.

INFORMANT **Anna F. Woodard**
(Address) **City Hospital #2**

15.

FILED **NOV 12 1927** **Mable Starvo**
19. **27** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov. 7, 1927**

17. I HEREBY CERTIFY That I attended deceased from **9/14** 19**27**, to **11/7/27** 19**27** that I last saw him alive on **11/7/27** 19**27**, and that death occurred, on the date stated above, at **11:30 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
109 A
indefinite (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) **100 A** (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED **not known**
IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? **no** DATE OF.....

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **clinical**
(Signed) **W. H. Russell** M. D.
, 19 (Address) **City Hosp. #2**

*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 **Truener Cemetery** DATE OF BURIAL **Nov. 13, 1927**

20. UNDERTAKER **E. C. Thomas** ADDRESS **3111 Lecky**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

