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

Do not use this space.
4028

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 7003
City St Louis Mo. (No. 4700 Minnesota St. ..... Ward)

File No. ..... Registered No. 642

2. FULL NAME Libby Foster

(a) Residence. No. 2947 A Cass St., 70 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May Bach 1856

7. AGE: Years: abt 72 Months: 7 Days: Unknown If LESS than 1 day, ... hrs. or ..... min.

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 COUNTY): Indiana

PARENTS
10. NAME OF FATHER: Harry Sherman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTY): N.Y.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTY): Mo

14. INFORMANT: Mrs. M. E. Gardner
(Address) 5800 Arbendale St.

15. FILED 1 1 1929 Chas. E. Stoddard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1/10 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1928, 19..., to Jan 10, 1929 that I last saw h. alive on Jan 10, 1929 and that death occurred, on the date stated above, at 11:55 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
235
122
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Unknown
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Physical Signs
(Signed) Myron E. Tank M. D.
1/11 1924 (Address) City Infirmary

*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: St Matthews Cem. DATE OF BURIAL: F 1/14 1929

20. UNDERTAKER: M Laughlin ADDRESS: 1631 Mo

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.