

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

Do not use this space.

24655  
3067

1. PLACE OF DEATH  
 County Jackson Registration District No. 398  
 Township Can. Primary Registration District No. 1902 File No. \_\_\_\_\_  
 City Keokuk No. W. Health & S. Providence Hospital Registered No. \_\_\_\_\_ (Ward)

2. FULL NAME Ernie Foman  
 (a) Residence. No. 114 E. 22nd St. 4 Ward. (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 4. COLOR OR RACE Colored  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 17-1908  
 7. AGE YEARS MONTHS DAYS 20 8 25 If LESS than 1 day, \_\_\_\_hra. \_\_\_\_min.  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Housemaid  
 (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) Tex.  
 10. NAME OF FATHER J. Foman  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tex.  
 12. MAIDEN NAME OF MOTHER Sally Sales  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tex.  
 14. INFORMANT J. Foman  
 (Address) 2038 E. 19th  
 15. FILED 1/14/29 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 1929  
 17. I HEREBY CERTIFY that I attended deceased from July 10<sup>th</sup> 1929 to July 12<sup>th</sup> 1929 that I last saw him alive on July 12<sup>th</sup> 1929, and that death occurred on the date stated above, at 11:40 a.m.  
 THE CAUSE OF DEATH\* was AS FOLLOWS:  
Memor'd Cyst  
5HE  
129  
 (duration) yrs. mos. da.  
 CONTRIBUTORY (SECONDARY) Peritonites (from rupture of cyst)  
 (duration) yrs. mos. da.  
 18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 0 DID AN OPERATION PRECEDE DEATH..... DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY No  
 WHAT TEST CONFIRMED DIAGNOSIS Autopsy  
 (Signed) J. W. Stewart  
 1/14/29 (Address) 1126 Forest  
 \*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 DATE OF BURIAL  
West Lawn Cemetery July 16 1929  
 20. UNDERTAKER ADDRESS  
West Lupton Jones 1600 E. 19th

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.

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