

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

Do not use this space.

37728

1. PLACE OF DEATH

County Lunington
Township Jackson
City (No. _____) _____

Registration District No. 962
Primary Registration District No. 2672

File No. 17
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Isabella 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 10 1850

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>		<u>5</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Homewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) hildon
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER W. French

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

12. MAIDEN NAME OF MOTHER Nancy McKenny

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Joe Foster
(Address) Sampson

15. FILED 12-5-29 N.L. White M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1929

17. HEREBY CERTIFY, That I attended deceased from Month 29 1929 to Nov 10 1929
that I last saw her alive on Nov 10 1929, and that death occurred, on the date stated above, at 11 A. m.,

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
821

CONTRIBUTORY (SECONDARY) 740
(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) A. S. Minnick, M. D.

Nov 6 1929 (Address) Lock Springs, 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

Lock Springs Cemetery DATE OF BURIAL Nov 18 1929
ADDRESS _____

20. UNDERTAKER

Amelia Breckenridge Mo.

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.

59
11/10/29

