

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

Do not use this space.

10003

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1007 File No. 1271
 City Kansas City (No. Trinity Lutheran Hosp) St. Mo. Ward 1271

2. FULL NAME Mary Jean Foster
 (a) Residence, No. 744 Chestnut St. City Kansas City Mo. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 10 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 Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22, 1920

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 6 27

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Kansas City (STATE OR COUNTRY) Missouri

10. NAME OF FATHER George H. Foster

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

12. MAIDEN NAME OF MOTHER Mary Hollington

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

14. INFORMANT George H. Foster (Address) 744 Chestnut St.

15. FILED 3/16, 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-14 1931

17. I HEREBY CERTIFY, That I attended deceased from 3-9-31 to 3-14-31 1931 that I last saw her alive on 3-13-31, and that death occurred, on the date stated above, at 2 ja m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis following ruptured appendix operable drainage
171A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 121 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 3-9-31

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS operable
 (Signed) A. S. Hickok, M. D.

(Address) 1025 Reallo Place
 *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. Moriah DATE OF BURIAL 3/16 1931

20. UNDERTAKER Greenwood Mortuary ADDRESS K.C. 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.

7/1/12