

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

Do not use this space.

38088

1. PLACE OF DEATH
 105 County Sullivan Registration District No. 447 853 File No. _____
 Township Liberty Primary Registration District No. 6117 Registered No. 19
 City _____ (No. _____) _____ St. _____ (Ward _____)

2. FULL NAME Wesmana Foye 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female
 4. COLOR OR RACE W
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 24 1924
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 7 2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-26 1932
 17. I HEREBY CERTIFY, That I attended deceased from 11-25 1932, to 11-26 1932, and that I last saw her alive on 11-25 1932 and that death occurred, on the date stated above, at 9:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Burn, clothing burned
acc. accidental

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Child
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

CONTRIBUTORY (SECONDARY) Toxemia
 (duration) _____ yrs. _____ mos. 2 ds.

9. BIRTHPLACE (CITY OR TOWN) Harris
 (STATE OR COUNTRY) Mo

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH no

10. NAME OF FATHER L. Senter Foster

DID AN OPERATION PRECEDE DEATH. no DATE OF _____

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

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) U.C. Weston, M.D.

12. MAIDEN NAME OF MOTHER Thebma & Stallman
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Grady co
 (STATE OR COUNTRY) Mo

11-27, 1932 (Address) Galt, 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.

14. INFORMANT L. Senter Foster
 (Address) Harris

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Half Rock
 DATE OF BURIAL 11-28 1932

15. FILED 11-27 1932 A.W. Widener
 REGISTRAR

20. UNDERTAKER H.C. Martin
 ADDRESS Harris

N. E.—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.

JAN 5 1933

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Sullivan
Township Liberty
City (No.)

Registration District No. 853
Primary Registration District No. 6119

File No.
Registered No. 19
St. Ward)

2. FULL NAME

Winona Faye 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

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

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry of business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED 11-29-32 AW Widmer Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11/26 1932

22. I HEREBY CERTIFY, That I attended deceased from to

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Bohemian W. S. Gessner clothing caught fire from cigarette while putting hog to boil
Date of onset 27
Other contributory causes of importance: Toxemia

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) M. D.
(Address)

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is VERY important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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