

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

Do not use this space.

25 1934

1. PLACE OF DEATH

County Daviess
Township Jamesport
City Jamesport (No. _____) St. _____ Ward _____

Registration District No. 252
Primary Registration District No. 5351

File No. 62386
Registered No. 48

2. FULL NAME

Emma Heaster

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-7-1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 11 25

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or 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) Harrison Co Mo

13. NAME James Collins

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

15. MAIDEN NAME Mary A Doolittle

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know

17. INFORMANT (ADDRESS) George Foster Jamesport Mo

18. BURIAL, CREMATION OR REMOVAL PLACE Antioch DATE 4-4-1934

19. UNDERTAKER (ADDRESS) S. M. Haas Putnam Mo.

20. FILED 4-4-1934 Nelle White Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-2-1934

22. I HEREBY CERTIFY, That I attended deceased from April 2, 1934, to Apr 2, 1934

I last saw him alive on Apr 2, 1934. Death is said to have occurred on the date stated above, at 9:30 a.m.

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

apoplexy

Date of onset

4/2-34

Other contributory causes of importance:

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 _____, 19 _____

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) J. P. Harry M. D.

(Address) Jamesport Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Laverne Registration District No. 25-2
 Township Jamezport Primary Registration District No. 25-35-1
 City (No. St. Ward)

File No. _____
 Registered No. 48

2. FULL NAME

Emma 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) M

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 or 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

UNDERTAKER (ADDRESS) Dr. Mr. Hass Bethany Mo

4-3 1934 Neel Wilcox Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 2, 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him _____ 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:

disapoplexy
cerebral
 Date of onset 4-4-34

Other contributory causes of importance:

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 _____, 19____

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC. THIS CERTIFICATE MUST BE COMPLETED AS PRESCRIBED BY L. S.

S-12386