

REC'D JUL 11 1938

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

21903

Do not use this space.

1. PLACE OF DEATH

(a) County Grundy Registration District No. 327
 (b) Township Galt Primary Registration District No. 4194 Registered No. 8
 (c) City Galt (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 1 yrs. 2 mos. 13 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Beverly Jack Foster

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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) Apr 15 - 1937
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 2 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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) Galt Mo.

13. NAME B. Eitel Foster

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osgood, Mo.

15. MAIDEN NAME Della Rusch

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

17. INFORMANT Terry E Foster (ADDRESS) Galt Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Berry Cemetery, Galt Mo. DATE June 30, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. Rogers Tiers Galt Mo.

20. FILED 6-30-38 W. C. Weston Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 28, 1938

22. I HEREBY CERTIFY, That I attended deceased from June 26, 1938, to 6-28-1938
 I last saw him alive on June 29, 1938. Death is said to have occurred on the date stated above, at 9:25 P.M.
 The principal cause of death and related causes of importance were as follows:

Indigestion of Bowels non specific

Date of onset 6-20-38

Other contributory causes of importance: none

Name of operation _____ Date of _____
 What test confirmed diagnosis? Specimen Was there an autopsy? No.

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) H. E. Bowers, M. D.
 (Address) Galt Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.