

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

11560
 Do not use this space.

DECD APR 19 1939

1. PLACE OF DEATH

(a) County Merced Registration District No. 039
 (b) Township Medicine Primary Registration District No. 0703 Registered No. 5
 (c) City (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Melissae M. Foster

(a) Residence, No. Harris St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Marian Foster

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 19 1885

7. AGE YEARS 54 MONTHS 2 DAYS 7 If LESS than 1 day, hrs. or min.

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

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 0

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

13. NAME Richard Moore

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

15. MAIDEN NAME Mary Handford

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

17. INFORMANT Marian Foster (ADDRESS) Thomas

18. BURIAL, CREMATION, OR REMOVAL PLACE Half Reef DATE 3-9-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. J. Funeral Home Merced

20. FILED 33 19 39 Mrs. Paul Thomas Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7 1939

22. I HEREBY CERTIFY That I attended deceased from March 5 1939 to March 7 1939

I last saw him alive on March 2 1939 Death is said to have occurred on the date stated above, at 1:15 p. m.

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

Date of onset

Other contributory causes of importance: 108

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 U.S. Bradley M. D.
 (Signed) U.S. Bradley (Address) Merced 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.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED
District Health Officer No. 11,
District File Number 39-306
Date Filed APR 11 1939

MAXX
State of Florida
Albuquerque

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.

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

115-60
Do not use this space.

1. PLACE OF DEATH

(a) County Mercer Registration District No. 559
 (b) Township Medicine Primary Registration District No. 575-3 Registered No. 0-
 (c) City (d) Street No.
 (e) Length of residence in city or town where death occurred) (If death occurred in Hospital or Institution, write its name instead of street and number)
 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MALISAE. D. Foster
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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.
34 2 7

OCCUPATION
 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)

FATHER
 13. NAME

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

MOTHER
 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3-8 1939 Mrs. Claud Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-7 1939

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

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:

Date of onset

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) U. S. Bradley, M. D.
 (Address) Harris Mf. O.

SUPPLEMENTARY

MAY 19 1930

RECEIVED
MAY 19 1930
U. S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

[The remainder of the page contains extremely faint and illegible text, likely a typed letter or report, which is mostly obscured by noise and low contrast.]