WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

LEG'D APR 7 1939

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

12278
Do not use this space.

1. PLACE OF DEATH
(a) County St. Louis 3 Registration District No. 784
(b) Township Primary Registration District No. 109 Registered No. 533
(c) or City Maplewood, Mo. (d) Street No. 2200 Bredell St.
(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. 14 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sophia Foerster
(a) Residence, No. St. NR Hermann Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe.
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jacob Foerster
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 27, 1854.
7. AGE Years 84 Months 9 Days 25 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife.
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) Aug. 1938.
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hermann Mo. 0

FATHER
13. NAME John Bohlken 6
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany.

MOTHER
15. MAIDEN NAME Sophia Grossman 6
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany.

17. INFORMANT (ADDRESS) John Foerster. 4045 Walsh
18. BURIAL, CREMATION, OR REMOVAL
PLACE Hermann, Mo. DATE 3/24/39. 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS) A.H.Hoppe, Inc. 4700 Washington.
20. FILED MAR 22 1939 S. R. Meyer M.D.D.P.H. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 22, 1939
22. I HEREBY CERTIFY, That I attended deceased from Mar. 9th 1939, to Mar. 22nd, 1939
I last saw her alive on March 22nd, 1939. Death is said to have occurred on the date stated above, at 6 10 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Apoplexy	3-1-39
Other contributory causes of importance: Essential Hypertension	1934

Name of operation None Date of —
What test confirmed diagnosis? Clinical 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? No
If so, specify
(Signed) Walter A. Greenwald, M. D.
(Address) 5005 A Gravois Ave.

(Licensed Embalmer's Statement on Reverse Side)

50M-9-1 I X16805

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 Guy W Wilbarson

Licensed Embalmer No. 3575

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.