

Registration District No. 2917

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 4418 Connecticut  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
(Specify whether years, months or days)  
In this community 6 years

3. (a) PRINT FULL NAME Marie Vernon Fosbage  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female  
5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Joseph Fosbage  
6. (c) Age of husband or wife if alive 37 years  
7. Birth date of deceased Feb 2 1889  
(Month) (Day) (Year)

8. AGE: Years 51 Months 1 Days 6  
If less than one day hr. min.

9. Birthplace Forsyth Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER { 12. Name Robert Bailly McManus  
13. Birthplace Unknown Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Caldonia Etheridge  
15. Birthplace Springfield Missouri  
(City, town, or county) (State or foreign country)

MOTHER { 16. (a) Informant's own signature Edna Sappenfield  
(b) Address 981 Inoka Kansas

17. (a) Burial (b) Date thereof ST. Matthews  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation

18. (a) Signature of funeral director W. M. Laughlin  
(b) Address 2301 Lafayette

19. (a) MAR 9 1940 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town ST. Louis 16  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4418 Connecticut  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 8  
year 1940 hour 10 minute 00 a.m.

21. I hereby certify that I attended the deceased from Oct 28, 1938, to March 8, 1940.  
that I last saw her alive on March 6, 1940.  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Cervix Uteri

Due to Metastases of Carcinoma of Cervix Uteri  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Duration \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury! \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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**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 Paul A. Keith

Licensed Embalmer No. 26152

P. O. Address 2317 Lafayette

**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.**