

SEP 16 1940

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

27923
Do not use this space.

1. PLACE OF DEATH
 (a) County Boone 2 Registration District No. 73
 (b) Township 0 Primary Registration District No. 30 66
 (c) City Columbia (d) Street No. _____ 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME RUTH VING RUTH FOSTER
 (a) Residence, No. 101 W. Park Ave St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-13-1861

7. AGE YEARS 79 MONTHS 3 DAYS 24 If LESS than 1 day, _____ hrs. or _____ min.

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

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) Boone County Mo

13. NAME Do Not Know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

15. MAIDEN NAME Do Not Know 17

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 1

17. INFORMANT (ADDRESS) Ruth Turner Detroit Mich.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE 8-12 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stuart P. Parker Columbia, Mo

20. FILED 8/12/1940 Allie Selby Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 7 1940

22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1940, to Aug 7 1940
 I last saw her alive on Aug 6 1940. Death is said to have occurred on the date stated above, at 6:00 p.m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of Intest & Bladder?

Date of onset

Other contributory causes of importance: none

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) Dr. Moore M. D.
 (Address) 301 N. W. St Columbia, Mo

K. 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.

WHILE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

48

7-16-17

1

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

John Parker
.....
Licensed Embalmer No. *2900*

P. O. Address *Columbus*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27923**
Registrar's No. **172**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **73**

Primary Registration District No. **3006**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Boone**
(b) City or town **Columbin**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Vina Ruth Foster**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **79** Months **3** Days **24** If less than one year _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month **Aug** day **7** year **1946** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that last saw h. _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of uterus & bladder**

Due to **Primary carcinoma of uterus**

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature **P. A. Moon** (M. D. or other) _____

Address **Columbia Mo** Date signed _____

Duration
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

