

Registration District No. 689
Primary Registration District No. 3032

1. PLACE OF DEATH:
(a) County Rike
(b) City or town Louisiana
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: South main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME BERTHA W. FOSTER
3. (b) If veteran, name war _____
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 James E. Foster
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased May 18 1896
(Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 4
If less than one day _____ hr. _____ min.

9. Birthplace Pleasant Hill townshp, Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Albert Cousins
18. Birthplace (?)

14. Maiden name Luise Ficklin
15. Birthplace (?)
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Ruth Gout
(b) Address Louisiana, Mo.

17. (a) Burial (b) Date thereof Oct 24/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Riverview Cem.

18. (a) Signature of funeral director H. Haley
(b) Address Louisiana, Mo.

19. (a) Oct 22 1940 (b) H. Haley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Rike
(c) City or town Louisiana Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. South main
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22
year 1940 hour 8 minute 40 P.M.
21. I hereby certify that I attended the deceased from October 12
1940, to October 22, 1940;
that I last saw her alive on October 22, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis
Cerebral hemorrhage
Due to Hypertension

Duration 8 1/2 hrs
10 days
3 years

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

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)
(e) Means of injury _____

23. Signature Eugene Pitts, M.D. (M. D. or other) M.D.
Address 4th and Georgia, Louisiana Date signed 10/23

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.

RECEIVED

District Health Officer No: 10

Case No. 11-40-2068
Date Filed NOV 8 1940

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.....

George O. Hagner, Registered Apprentice No.
working under my personal supervision.

Signed *George O. Hagner*
Licensed Embalmer No. *3773*
P. O. Address *Louisiana Mo*

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.