

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31992**

Registrar's No. **114**

LED SEP 16 1945
Registration District No. **125**

Primary Registration District No. **4275**

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Marionville
(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) 1
(d) Length of stay: In hospital or institution 1
(Specify whether
In this community Yes (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Patricia Ann Foster

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced divorced chafant

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive 15 years (Day) (Year)

7. Birth date of deceased Oct 15th 1939
(Month) (Day) (Year)

8. AGE: Years 3 Months 10 Days hr. min.
If less than one day

9. Birthplace Marionville Mo. U
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER { 12. Name Aurby Foster

13. Birthplace Marionville Mo U
(City, town, or county) (State or foreign country)

14. Maiden name Mildred Galloway

15. Birthplace Marionville Mo U
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Aurby Foster

(b) Address Marionville Dist 203 Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 17 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Marionville Cem

18. (a) Signature of funeral director Wallace Funeral

(b) Address Billingg Mo

19. (a) 8-17-1945 (Date received local registrar) (b) Lucille Greene by (Registrar's signature) 4702

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence
(c) City or town Marionville
(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. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15 year 1943 hour 9:20 pm minute M.

21. I hereby certify that I attended the deceased from Aug 14, 1943, to Aug 15, 1943; that I last saw he alive on Aug 15, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Encephalitis, acute Duration 5 da

Due to

Due to 37a

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) no

(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

28. Signature RD Cowan D (M. D. or vet med)

Address Aurora, Mo Date signed 8/17/45

943-1093
9-14-43

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 ML

....., Registered Apprentice No. For Wallace Funeral Home
working under my personal supervision. Billings MO.

Signed C. J. Floyd

Licensed Embalmer No. 3527

P. O. Address Billings 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.