

FILED AUG 10 1944

Registration District No. **324**

Primary Registration District No. **322**

Registrar's No. **131**

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

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall  
(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 10 days (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME BIRDIE FOSTER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Unknown (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 9 1886  
(Month) (Day) (Year)

8. AGE: Years 58 Months X Days X If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saline Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robert Foster

13. Birthplace Saline Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Henley Green

15. Birthplace Saline Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Nancy Foster

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof July-11-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo

18. (a) Signature of funeral director F. B. Ferguson

(b) Address Beulah Mo

19. (a) 7-11-44 (b) Mo T. A. Wehbeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97

(c) City or town Marshall  
(If outside city or town limits, write "RURAL")

(d) Street No. 750 W Boyd  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from no \_\_\_\_\_ 1943 to July 9 1944  
that I last saw her alive on July 9 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Ch. Myocarditis.  
ac. nephritis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations none  
Of autopsy no

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 \_\_\_\_\_

23. Signature Robert Ferguson (M. D. or other) \_\_\_\_\_  
Address Marshall Mo Date signed 7-10-44

Duration \_\_\_\_\_

15 yrs.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

1213

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 8-9-47

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 F. D. Ferguson  
Licensed Embalmer No. 2172  
P. O. Address Safalia

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, fact should be so stated above.