

S. No. 2
DOM--2-43
ev. 5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7259

FILED MAR 31 1945
Registration District No. 3-2-45

Primary Registration District No. 6093

Registrar's No. 25

1. PLACE OF DEATH: Saline

(a) County Saline

(b) City or town Marshall, Route # 3.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Marshall
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Sixty years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97

(c) City or town Marshall, Route # 3
(If outside city or town limits, write "RURAL") 1

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____ 1

3. (a) PRINT FULL NAME Lillie May Foster

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 24
year 1944 hour 2 minute 0 P. M.

21. I hereby certify that I attended the deceased from Feb 17, 1944, to Feb 24, 1945;
that I last saw he alive on Feb 20, 1945;
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife James B. Foster 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased October 15, 1877
(Month) (Day) (Year)

Immediate cause of death _____

Chr. Myocarditis 10 yrs.

Due to _____

Chr. Nephritis 12 yrs.

Due to _____

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

8. AGE: Years Months Days If less than one day

67	4	9	hr. min.
----	---	---	----------

9. Birthplace Illinois /
(City, town, or county, - (State or foreign country)

10. Usual occupation House keeper

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name James M. Griffin

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

14. Maiden name Eveline Foster

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

16. (a) Informant James B Foster

(b) Address Marshall, Mo. Route # 3

17. (a) Burial (b) Date thereof 3-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park cemetery

18. (a) Signature of funeral director Campbell Rini

(b) Address Marshall, Mo.

19. (a) 2-28-45 (b) Mother
(Date received from registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence _____

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) (or Means of injury)

23. Signature Robert M. ... (M. D. or other) 0

Address Marshall Mo Date signed 3-23-45

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

700

1215

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 3/12/45
Date Filed 3/12/45

APR 20 1945

APR 17 1945

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 R. W. Campbell Jr.
Licensed Embalmer No. 3469
P. O. Address Marshall 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, fact should be so stated above.