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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 5 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18832

Primary Registration District No.

Registrar's No. 5182

1003

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 48 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1219 N 21st St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Marie Foster
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter Foster
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan. 1 1876 (Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 22 If less than one day hr. min.

9. Birthplace Mississippi (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John Davis
13. Birthplace Mississippi (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Lillian ?
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Walter Foster
(b) Address 1219 N. 21st Street
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director Dement & Son
(b) Address 2629-31 Cole Street
19. (a) MAY 26 1947 (Date received by registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 22 year 1947 hour 12 minute 20 P.M.
21. I hereby certify that I attended the deceased from 4-4, 1947, to 5-22, 1947 that I last saw her alive on May 22, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Embolus - Pulmonary	Undet.
Due to:	
Due to:	
Other conditions: Hemi-colectomy (surgical) (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Yes

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (Yes or No) Means of injury
23. Signature Edw. P. Williams (M. D. or other)
Address 2601 N Whittier Date signed 5/24/47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3439

P. O. Address 4575 Aldine

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 316 Primary Registration District No. 1003 Registrar's No. 4737

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(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
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 5184

(a) State (b) County

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

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

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

If yes, name country

3. (a) PRINT FULL NAME Marie Foster

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan (Month) (Day) 1894 (Year)

8. AGE: Years 64 Months 4 Days 27 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

JUN 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 22
year 1947 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S- 18832