S. No. 2
M—1/47
7. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 21 1947

Registration District No. 7

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 29893

Registrar's No. 1728

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 11 days (Specify whether years, months or days)
In this community: all 4 years

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.: 2602 Stoddard
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Georgia Foster
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: F
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: divorced
6. (b) Name of husband or wife: Wilbert Foster
6. (c) Age of husband or wife if alive: 14 years
7. Birth date of deceased: 6 (Month) 14 (Day) '20 (Year)
8. AGE: Years 27 Months 1 Days 21 If less than one day hr. min.
9. Birthplace: Hughes (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation: Clerk
11. Industry or business:
FATHER 12. Name: Burton Norris
13. Birthplace: Memphis (City, town, or county) Tennessee (State or foreign country)
MOTHER 14. Maiden name: Mary Morgan
15. Birthplace: (City, town, or county) Arkansas (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-15-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Washington Park
18. (a) Signature of funeral director: Howard Funeral Home
(b) Address: 2834 Gamble
19. (a) 8-12-47 (Date received local registrar) (b) Carl A. Sharpe (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 10 year 1947 hour 7 minute 50 P.M.
21. I hereby certify that I attended the deceased from August 1, 1947, to August 10, 1947, that I last saw her alive on August 10, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	??
Due to:	
13 b	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (e) Means of injury:
23. Signature: Bernard Freeman (M. D. or other)
Address: Robt. Koch Hosp. Date signed: 8/11/47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

AUG 21 1947

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 Chas. L. Hoewell

Licensed Embalmer No. 2452

P. O. Address 2834 Gamble

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.