

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.

1930 JUN 15 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Livingston
Township Cream Ridge
City 236 (No. 236)

Registration District No. 508
Primary Registration District No. 5677

File No. 19126
Registered No. 80
St. Linneus Ward Missouri

2. FULL NAME

Mary Ann Foster

(a) Residence, No. 236 St. Linneus Ward Missouri
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---|----------------------------------|---|
| 3. SEX <u>Female</u> | 4. COLOR OR RACE <u>White</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>G. F. Foster</u> | | |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 20, 1869</u> | | |
| 7. AGE YEARS <u>69</u> | MONTHS <u>10</u> | DAYS <u>0</u> |
| If LESS than 1 day, hrs. or min. | | |

| | |
|---|---|
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u> |
| | 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. |
| 10. Date deceased last worked at this occupation (month and year) <u>April 19, 1939</u> | 11. Total time (years) spent in this occupation |

| |
|---|
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sullivan County Missouri</u> |
|---|

| | |
|--------|---|
| FATHER | 13. NAME <u>George W. Knifong</u> |
| | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>XXXXXXX Virginia</u> |

| | |
|--------|---|
| MOTHER | 15. MAIDEN NAME <u>Martha Pipes</u> |
| | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>XXXXXXX Kentucky</u> |

| |
|--|
| 17. INFORMANT (ADDRESS) <u>Jesse Foster Linneus, Missouri</u> |
|--|

| |
|--|
| 18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Elmwood Cem.</u> DATE <u>4/22/1939</u> |
|--|

| |
|---|
| 19. UNDERTAKER (ADDRESS) <u>Thorne Undertaking Co. Linneus, Missouri</u> |
|---|

| |
|-------------------------------|
| 20. FILED <u>19</u> REGISTRAR |
|-------------------------------|

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from 4/20, 1939, to 4/20, 1939.
I last saw h.e.r. alive on 7/20, 1939. Death is said to have occurred on the date stated above, at 1:30 A.M.
The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Date of onset 4/19

Other contributory causes of importance: 94

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify _____
(Signed) Chas. M. Crea M.D.
943 (Address) Chas. M. Crea M.D.

RECEIVED
District Health Officer No. 111
11-27-2011
Quinine File Number
JUN 14 1939
Date Filed

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

19126
Do not use this space.

1. PLACE OF DEATH

(a) County Lumpkin Registration District No. 508
(b) Township Cream Ridge Primary Registration District No. 5677
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of str. and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 80

2. PRINT FULL NAME

(a) Residence, No. _____ St. _____
(Usual place of abode; if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF G. I Foster

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-20-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
69 11 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) Apr 1939
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Sullivan
(STATE OR COUNTRY)

13. NAME Geo W Knifong

14. BIRTHPLACE (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

15. MAIDEN NAME Martha Jones

16. BIRTHPLACE (CITY OR TOWN) Day
(STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Jesse Foster
Lanterns

18. BURIAL, CREMATION, OR REMOVAL PLACE Elmwood DATE 4/22 1939

19. FUNERAL DIRECTOR (ADDRESS) Thorne vudt co.
Lanterns

20. FILED 7-3 1939 H. McCrear Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-20 1939

22. I HEREBY CERTIFY, That I attended deceased from 4-1-20 1939 to 4-20 1939

I last saw her alive on 4-20 1939. Death is said to have occurred on the date stated above, at 1:30 m.
The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) O. K. McCrear M.D.

(Address) Chula Mo.

3