MAR 16 1928

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

Do not use this space.

4009

1. PLACE OF DEATH

County: Bollinger — Registration District No.: 69 — File No.: 6

Township: Wayne — Primary Registration District No.: 5108 — Registered No.:

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME Margaret Ellen Foster

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22 1928

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
			25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓ 118
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 158
(c) Name of employer ✓

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ark.

PARENTS

10. NAME OF FATHER W. J. Foster

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Ada F Belcher

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo.

14. INFORMANT W. J. Foster
(Address) Palma Mo

15. FILED 2/17, 1928 A. T. Kirkpatrick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 17 1928

17. I HEREBY CERTIFY, That I attended deceased from ..... Died before ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... I arrived at ..... and that death occurred, on the date stated above, at their home

THE CAUSE OF DEATH* WAS AS FOLLOWS:
I think ✓
Indigestion
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED At
IF NOT AT PLACE OF DEATH? ✓
0 DID AN OPERATION PRECEDE DEATH? no. DATE OF ✓
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) A. T. Kirkpatrick, M. D
, 19 (Address) Palma Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Union Hill Cemetery	Feb. 18 1928
20. UNDERTAKER	**ADDRESS**
Frank Pohle	Palma Mo

...ppliedly ... should be ... PERSONS should state ... that it ... properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied, and the AGE should be stated EXACTLY. Any error in the CAUSE OF DEATH may be properly fatal. Exactness in this is very important.

NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ... ETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.
County: Bollinger — Registration District No.: 69 — File No.: 5
Township: Wayne — Primary Registration District No.: 5108 — Registered No.:
City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Margeret Ellen Foster

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

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: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 22 - 1925

7. AGE — YEARS: ..... MONTHS: ..... DAYS: 25 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED ....., 19 ..... A. T. Kirkpatrick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2 - 17 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw b..... alive on ....., 19..., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Stomach Indigestion
Artificial Feeding
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

#2 C

S-40007