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

Do not use this space. 17629

1. PLACE OF DEATH
County: Lafayette — Registration District No.: 464 — File No.: 12
Township: No. — Primary Registration District No.: 5626 — Registered No.: 36
City: Mayview (No. ..... St. ..... Ward)

2. FULL NAME: Miss Willie M. 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: Unknown yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown

7. AGE: 8 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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: John Foster
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Va.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Elizabeth ?
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Va.
(STATE OR COUNTRY)

14. INFORMANT: E. S. Burch
(Address): Mayview Mo.

15. Filed June 10 1928 R. A. Helvoodley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 22 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 1928, to May 26 — 1928 that I last saw h. alive on May 25 — 1928, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
93D (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 906
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) [illegible], M. D.
5/27 1928 (Address) Mayview, 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: Mt Hebron — DATE OF BURIAL: May 27 1928

20. UNDERTAKER: R. A. Hodes — ADDRESS: Higginsville Mo

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.