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

Do not use this space.

24614

1. PLACE OF DEATH

County ..... Registration District No. 791 1006

Township ..... Primary Registration District No. .....

City St Louis (No. 5040 Idaho Ave St. ..... Ward)

File No. .....

Registered No. 6772

2. FULL NAME Elizabeth Foster

(a) Residence. No. 5048 Idaho Ave St., 15 Ward. (If nonresident, give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 12-1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	9	29	

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

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

PARENTS

10. NAME OF FATHER Patrick Doyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Mary Hopkins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Mrs Mary Strauss
(Address) 5040 Idaho Ave

15. FILED JUL 12 1930 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 2 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemiplegia
Apoplectic
82 H (duration) yrs. mos. ds.

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

Mark J. W. Lemon
by Corona
7/10/30

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? .....

(Signed) Chas. Henke, M. D.
7/12, 1930 (Address) 900 Russell Blvd

*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
Calvary Cemetery	July 14 1930
20. UNDERTAKER	ADDRESS
Peetz Bros 3029	Lafayette

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.

Dr C.F. Henke.
90: Russell.
9-11-

Gen OK by Cormer