

STANDARD CERTIFICATE OF DEATH

State File No. 22094

REC'D JUL 15 1940

Registration District No. 449

Primary Registration District No. 5609

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEONON TWP.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community all her life (Specify whether years, months or days) 23 1/2

3. (a) PRINT FULL NAME EUNICE HOOKER FOSTER

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife W.P. FOSTER 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPT 5 1860
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace LACLEDE CO MO
(City, town, or county) (State or foreign country)

10. Usual occupation FARMING

11. Industry or business _____

12. Name WM. HOOKER

13. Birthplace US
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH ELLIS

15. Birthplace US
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jared Foster

(b) Address Leonon Mo

17. (a) Burial (b) Date thereof 5 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leonon

18. (a) Signature of funeral director Johnnie

(b) Address Leonon Mo

19. (a) 5-24-40 (b) J. A. McCoub
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Laclede
(c) City or town Leonon (If outside city or town limits, write "RURAL")
(d) Street No. R. 3 1/2 (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 24
year 1940 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to May 24, 1940,
that I last saw her alive on May 23, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis and nephritis and senility Duration _____
Due to Pneumonia and 7 weeks ago Fall ✓
Due to and fractured hip

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. L. Benway (M. D. or other) _____
Address Leonon Mo Date signed 5/24/40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

1876A
2981
69

RECEIVED
District Health Officer No. 7,
District File Number 7/140/948
Date Filed 7/1/40

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 D. P. Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22094**
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **449**

Primary Registration District No. **5609**

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County **Laclede**
(b) City or town **Lebanon T. P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Eunice Hooker Foster

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **79** Months **8** Days **19** If less than one year _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: month **May** day **24** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h_____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis**
and nephritis

seizure

Duct **Pneumonia and 7 days to 10**
ago Fall and Fract

Other conditions _____ (Specify conditions within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, ~~suicide~~ or homicide (specify) **Fall at Home**

(b) Date of occurrence **4/6-1940**

(c) Where did injury occur **at home** (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature **J. L. Bunge** (M. D. or other) _____
Address **Lebanon Mo** Date signed _____

SUPPLEMENTAL

