

No. 2
4-13-40
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X2315

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22855**

Registration District No. **111**

Primary Registration District No. **111**

Registrar's No. **1217**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**

(b) City or town **Rich. Hgts.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. MARY'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 day**
(Specify whether years, months or days)

In this community **years, months or days**

3. (a) PRINT FULL NAME **FOSTER, EVA** **236**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NO**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **John Foster**

6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **Nov. 11 1890**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

59 7 15 hr. min.

9. Birthplace **MARION COUNTY Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE & SCHOL TEACHER**

11. Industry or business

12. Name **HENRY EASLEY**

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

14. Maiden name **EDITH TRACY**

15. Birthplace **MARION CO. ILLS.**
(City, town, or county) (State or foreign country)

16. (a) Informant **MARY FOSTER**

(b) Address **CENTRALIA, ILLS.**

17. (a) **BURIAL** (b) Date thereof **JUNE 28, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hill Crest Memorial Park Centralia, ILLS.**

18. (a) Signature of funeral director **Ray**

(b) Address **3029 LAFAYETTE AVE.**

19. (a) **JUN 28 1940** (b) **AK Meyer**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Marion**

(c) City or town **RACCOON TOWNSHIP**
(If outside city or town limits, write "RURAL")

(d) Street No. **RACCOON TOWNSHIP**
(If rural, give location)

(e) If foreign born, how long in U. S. A. **years.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **26**
year **1940** hour **12** minute **10** P.M.

21. I hereby certify that I attended the deceased from **June 25**
1940 to **June 26** **1940**
that I last saw h. **er** alive on **June 26** **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death

Abscesses of liver to localized Peritonitis **24 hrs**

Due to **Stone in Common duct.** **1 year**

Due to

Other conditions **Acute Pancreatitis** **24 hrs**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations **26**

Of autopsy: **Same as above**

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)

(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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature **W. Brennan M.D.** (M. D. or other) **1**
Address **1529 N. Grand St.** Date signed **6/21/40**

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

MOTHER FATHER

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 Frank J. Dwyer

Licensed Embalmer No. 2245

P. O. Address St. Louis, 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, fact should be so stated above: