

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26661**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6557**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4419 Blair Ave **2**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution None
(Specify whether
 In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis **9**
(If outside city or town limits, write "RURAL")
 (d) Street No. 2030 Gano Ave
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
 year 1940 hour 7:15 AM minute _____ M.
 21. I hereby certify that I attended the deceased from Oct 15, 1939
July 29, 1940, to July 29, 1940
 that I last saw her alive on July 29, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage
(Apoplexy)
 Due to: Hypertension
 Due to: Chronic Nephritis
 Other conditions: _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

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

3. (a) PRINT FULL NAME Lillie Foster **236**
 3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James H. Foster 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased July 27, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 0 2 hr. _____ min.

9. Birthplace St. Louis, Missouri **6**
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name Frederick Strohbeck

13. Birthplace Germany **6**
(City, town, or county) (State or foreign country)

14. Maiden name Amelia M. Schmittings

15. Birthplace Germany **6**
(City, town, or county) (State or foreign country)

16. (a) Informant James H. Foster **6**

(b) Address 4419 Blair Ave

17. (a) Burial (b) Date thereof 8/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) AUG 2 1940 (b) J. F. Strohbeck
(Date received local registrar) (Registrar's signature)

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 Arthur J. de May (M. D. or other) **1**
 Address 4046 N. Grand Blvd. Date signed 7/31/40

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

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 *Samuel Hampton*

Licensed Embalmer No. *2967*

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, above space should be left blank.