FILED JUN 25 1942

S. No. 2
—1-4-41
5-17-39
PI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

19157

State File No. 19157

Anderson

Registration District No. 821 Primary Registration District No. 4503 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Sikeston General Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 100

(a) State Missouri (b) County Scott 5

(c) City or town Sikeston 2
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location) 0

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William James Foster

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 5 (Month) 31 (Day) 1942 (Year)

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Sikeston (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Doyle Foster
13. Birthplace Star (City, town, or county) Okla. 1 (State or foreign country)

MOTHER
14. Maiden name Mildred Lomax
15. Birthplace New Madrid (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Doyle Foster
(b) Address Matthews Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/1/42 (Month) (Day) (Year)
(c) Place: burial or cremation New Madrid Mo.

18. (a) Signature of funeral director Hunter Albritton
(b) Address Sikeston Mo.

19. (a) 6-1-42 (Date received local registrar) (b) H B Throgmorton, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 1
year 1942 hour 12 minute 30 a M.

21. I hereby certify that I attended the deceased from 5-31-1942 to 5-31 1942
that I last saw him alive on 5-31 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Atelactasis Neonatorum — Duration 6 hours

Due to Mucus Swallen

Due to Seering Breech extraction

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no 161a
Of autopsy no

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) none
(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 0

23. Signature M G Anderson (M. D. or other)
Address Sikeston Date signed 6-1-42

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

1039 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 642-738
Date Filed JUN 18 1947

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

Not Embalmed, Registered Apprentice No.

working under my personal supervision.

Signed Hunter Allenitt

Licensed Embalmer No. 4210

P. O. Address Sikeston 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.