. No. 2
M—2-43
5-17-39
I X35637

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 18 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34164

Registration District No. 198 Primary Registration District No. 4310 Registrar's No. 15

1 1 0

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: Bevier
(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 — (Specify whether years, months or days)
In this community —

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Macon
(c) City or town: Bevier
(If outside city or town limits, write "RURAL")
(d) Street No.: — (If rural, give location)
(e) Citizen of foreign country? — (Yes or No?)
If yes, name country —

3. (a) PRINT FULL NAME: Minnie Foster
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Female
5. Color or race: wh
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband ~~or wife~~: George Foster
6. (c) Age of husband or ~~wife~~ if alive: 65 years
7. Birth date of deceased: 9 (Month) 1 (Day) 1879 (Year)
8. AGE: Years 71 Months 0 Days 13 If less than one day — hr. — min.
9. Birthplace: Bevier (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: Lewis Roberts
MOTHER FATHER
12. Name: Mao
13. Birthplace: Mo (City, town, or county) (State or foreign country)
14. Maiden name: Nina Patrick
15. Birthplace: Mo (City, town, or county) (State or foreign country)
16. (a) Informant: George Foster
(b) Address: Bevier Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-24-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Antioch
18. (a) Signature of funeral director: W. S. Edwards
(b) Address: Bevier Mo
19. (a) 9-26-45 (Date received local registrar) (b) Winnie T. Rowland (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 18 year 1945 hour 10 minute 30 P.M.
21. I hereby certify that I attended the deceased from July 16, 1945, to Sept 18, 1945; that I last saw h. on alive on Sept. 18, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Myocarditis	2 days
Due to Chronic Myocarditis	✓
Due to Hypertensive Heart Disease	
Other conditions (Include pregnancy 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)
(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: R. D. Madsen (M. D. or other)
Address: Macon, Mo Date signed 9/24/45

1289 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-45-1539
Date Filed OCT 17 1945

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 W. G. Edwards

Licensed Embalmer No. 1961

P. O. Address Bowie Tex

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.