

**FILED MAR 13 1948**  
64

Registration District No. **64**

Primary Registration District No. **5245**

Registrar's No. **11**

1. PLACE OF DEATH:

(a) County **Chariton**

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

(c) Name of hospital or institution:  
**5 mile N. W. of Keytesville**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community **all the life**  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Chariton**

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

(d) Street No. **Keytesville Imp. 5 mile N. W. Keytesville**  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **DELIAH. FRANCES. FOSTER.**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **27** 19**46**  
year **1946** hour **4** minute **0** P. M.

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

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

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

6. (c) Age of husband or wife if alive **5** years

7. Birth date of deceased **March 15 1897**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **January 1 1946** to **February 22 1946**; that I last saw him alive on **Feb 21 1946** and that death occurred on the date and hour stated above.

8. AGE: Years **89** Months **11** Days **7** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Ch. Myocarditis**

Duration **Don't know**

9. Birthplace **Livingston County Mo.**  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation **Housewife**

PHYSICIAN

Underline the cause to which death should be charged statistically.

11. Industry or business **John W. Wilkerson**

12. Name **John W. Wilkerson**

13. Birthplace **Don't know Va.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Jessie**

15. Birthplace **Don't know Va.**  
(City, town, or county) (State or foreign country)

Major findings: Of operations **930**

Of autopsy \_\_\_\_\_

16. (a) Informant **Mrs. J. P. Foster**

(b) Address **Marshalltown Iowa**

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? \_\_\_\_\_

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Feb. 24-1946**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Keytesville**

While at work? \_\_\_\_\_ (Specify type of place)

(i) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director **H. G. & Sonnet**

(b) Address **Keytesville Mo.**

19. (a) **Delia H. Foster** (b) **Delia H. Foster**  
(Type received local registrar) (Registrar's signature)

23. Signature **Carl C. Heger** (M. D. **1946**)

Address **Keytesville, Mo.** Date signed **2/25/46**

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

3931

21  
0  
0

2-25-46

55 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 2-12-46

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 H. D. Barnett

Licensed Embalmer No. 3046

P. O. Address 744 Taville M

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.