OCT 28 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

29064

File No.

Registered No.

1. PLACE OF DEATH
County Barry
Township Washburn
City (No. St. Ward)
Registration District No. 37
Primary Registration District No. 37 53

2. FULL NAME Vesta Expeltine Foster

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	White	Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED
(HUSBAND OF (OR) WIFE OF
Robert James Foster

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
83	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER Thos Ault
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.
12. MAIDEN NAME OF MOTHER Elaine Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tenn.

14. INFORMANT Mrs Thos J. Foster
(Address)

15. FILED 9/16 1930 J. S. Hankins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-14- 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 to Sept 14, 19..
during last illness; that I last saw her alive on Sept 14, 1930, and that death occurred, on the date stated above, at 8 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Face and
resulting complications
52

(duration) 5 m 6 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Do not know
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) S. W. Chandler, M. D.
, 19 (Address) Cassville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Shadden Prairie
DATE OF BURIAL 9-16 1930

20. UNDERTAKER Barr & Blankenship
ADDRESS Exeter, Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Barry Registration District No. 37 File No.
Township Washington Primary Registration District No. 3053 Registered No.
City (No. , St. Ward)

2. FULL NAME Vesta Eggelina Foster

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	wid

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF 1836

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10/29/1836

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
83	11	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED ...19... J S Foster REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-14-1930

17. I HEREBY CERTIFY, That I attended deceased from ...19... to ...19...
that I last saw h... alive on ...19..., and that death occurred, on the date stated above, at ...m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

...(duration)...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) ...(duration)...yrs. ...mos. ...ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ..., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

WRITE PLAINLY, WITH UNFADING INK. USE A PEN.

S-29064