MAY 27 1930

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

Do not use this space.

U 13752 ~~12226~~

1. PLACE OF DEATH

County St. Francois Registration District No. 33 File No.

Township Randolph Primary Registration District No. 6004B Registered No. 9

City Leadwood, Mo. (No. St. Ward)

2. FULL NAME Barbara E. Foster

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

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 F.

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF H. C. Foster

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 14-1867

7. AGE Years 62 Months 9 Days 3 If LESS than 1 day, ...hrs. or ....min.

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) Palmer Mo.
(STATE OR COUNTRY) Washington Co

PARENTS

10. NAME OF FATHER Richard M Robinson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Judy A. Wright

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Washington Co. Mo

14. INFORMANT
(Address)

15. FILED 5/9 1930 H Ellenbrecht REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 17 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-6 1930, to 4-17 1930 that I last saw her alive on 4-7 1930, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Carcinoma of uterus

48

(duration) 2 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) N. M. Tuell M. D

4/17, 1930 (Address) Desloge 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 Parkview Cem

DATE OF BURIAL 4/19 1930

20. UNDERTAKER Boyer

ADDRESS Leadwood

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

be carefully supplied

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 St. Francois   Registration District No. 33   File No.
Township Randolph   Primary Registration District No. 6024 B   Registered No. 9
City   (No.   St.   Ward)

2. FULL NAME Barbara E. Forster

(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.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE   YEARS   MONTHS   DAYS   If LESS than 1 day, ...hrs. or ......min.

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) Unknown
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT R M Fuller
(Address) Desloge Mo

15. FILED 6/5, 1930 W E Albrecht
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 17 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

WRITE PLAINLY, -THIS IS A PERMANENT RECORD

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

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