

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.

Registration District No. 257

Primary Registration District No. 3036

Registrar's No. 167

1. PLACE OF DEATH:
(a) County WARREN St. Charles
(b) City or town St. Charles
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles B. Foster 236
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Harriet Ellen Dixon 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased August 15, 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 2 Days 28 If less than one day hr. min.

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

10. Usual occupation Painter & paperer-retiree

11. Industry or business

MOTHER FATHER
12. Name John Foster
13. Birthplace North Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Mary Fitzgerald
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas. Foster
(b) Address Winfield, Missouri
17. (a) Burial (b) Date thereof 11/17/39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Winfield Cemetery

18. (a) Signature of funeral director O. S. Ricks
(b) Address Winfield, Missouri
19. (a) 11/13/39 (b) Charles H. Heister
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lincoln
(c) City or town Winfield
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 13th
year 1939 hour 11 minute 40 P. M.
21. I hereby certify that I attended the deceased from Nov 9, 1939, to November 13, 1939;
that I last saw him alive on November 13, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis - Duration _____
Due to chronic hypertensive / 21
hyper tension
Due to Renal obstruction
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy no
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Vernant A. Schurdt (M. D. or other) _____
Address St. Charles, Mo. Date signed 11/17/39

3-11-1918

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.....
Garlan Ricks

Licensed Embalmer No..... **4018**.....

P. O. Address..... **Winfield, Missouri**.....

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, above space should be left blank.