

FILED APR 10 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 9025
Registrar's No. 2508

791

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: De Paul Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Moses F. Foster

3. (b) If veteran, name war World War 3. (c) Social Security No. 489-07-6555

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Estel G. Foster 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased November 9, 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>44.</u>	<u>4.</u>	<u>5.</u>	hr. _____ min.

9. Birthplace Ordioles-Stoddard, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Merchandise Man

11. Industry or business F.W. Woolworth Co

MOTHER FATHER { 12. Name Frank P. Foster }
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant R. K. Bennett

(b) Address 444 Park Rd. Webster

17. (a) burial (b) Date thereof 3-16-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cem.

18. (a) Signature of funeral director C. R. Eipton + Sons

(b) Address #7233 Delmar Blvd.

19. (a) MAR 15 1940 (b) J. P. [Signature]
(Date received from Registrar) (Signature of Registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City, N.R.
(If outside city or town limits, write "RURAL")
(d) Street No. # 4029 Kingsbury
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14
year 1940 hour 5 20 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 19
1940 to March 14, 1940
that I last saw him alive on March 14, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Haemorrhage
pacchy meningitis
Due to interna
92a

Other conditions: Pyelitis, non-calculous
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: Cerebral Haemorrhage
pacchy meningitis

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 H. H. [Signature] (M. D. or physician)
Address 984 Acade Bldg Date signed 3/15/40

Duration 8 hrs
Special Examiner
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Miss. Clerk
A. J. Karamalawsky h. D.
Arcade Bldg.
Ch. 5894
1-2 P.M.

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.....

Don Muschery....., Registered Apprentice No. 289
working under my personal supervision.

Signed Clarence H. Murray.....

Licensed Embalmer No. 4011.....

P. O. Address St. Louis Mo......

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.