

FILED JUN 15 1940

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 2604

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2503 Park Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 27 years
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Maola Foster 236

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Thomas Foster 6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased June 15, 1898
(Month) (Day) (Year)

8. AGE: Years 42 Months _____ Days 10 If less than one day hr. _____ min. _____

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

10. Usual occupation Maid

11. Industry or business _____

MOTHER { 12. Name Thomas Jones

13. Birthplace Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Eliza Eays

15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Eliza Jones

(b) Address 2503 Park

17. (a) burial (b) Date thereof 6/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shawnee, Kansas

18. (a) Signature of funeral director Watkins Bros.

(b) Address 1729 Lydia

19. (a) June 27, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2503 Park Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 25
year 1940 hour 9 minute 10 A. M.

21. I hereby certify that I attended the deceased from 6-24
1940, to 6-25, 1940
that I last saw he alive on 6-25, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Infarction & Intestinal
obstruction (acute)
Duration 48 hrs.

Due to _____

Due to 12/2/00

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

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 M. M. Brown (M. D. or other)

Address 1009 E. 18th Date signed 6/26/40

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

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

Isaac Jerome Mylove

Licensed Embalmer No.

3994

P. O. Address

1120 E. 23rd St.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20987

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2604

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

1. PLACE OF DEATH:

(a) County. Jackson

(b) City or town. J.C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME. Maola Foster

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex. 7 5. Color or race. col 6. (a) Single, widowed, married, divorced. m

6. (b) Name of husband or wife. 6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
42 - 10 hr. min.

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

10. Usual occupation.

11. Industry or business.

12. Name

13. Birthplace. (City, town, or county) (State or foreign country)

14. Maiden name. (City, town, or county) (State or foreign country)

15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address

19. (a) 6/27/40 (Date received local registrar) (b) M.M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.

(c) City or town. (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.

20. DATE OF DEATH. Month 6 day 25 year 1940 hour minute M.

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

Immediate cause of death

Due to

Due to

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 A. F. Radford (M. D. or other) Address K. C. Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

