

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26140**

Registration District No. **761**

Primary Registration District No. **4456**

Registrar's No. **26**

1. PLACE OF DEATH:

(a) County **St. CLAIR**
(b) City or town **Appleton City, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **1st St - Nickerson**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **50 yrs**
(Specify whether years, months or days) **27 1/2**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Henry**
(c) City or town **3 miles NW of Montrose**
(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.

3. (a) PRINT FULL NAME **RUFED. Columbus Foster**

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

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

6. (b) Name of husband or wife **RRA FOSTER** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **Feb. 17 1865**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 5 10 hr. min.

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

10. Usual occupation **FARMER**

11. Industry or business

MOTHER FATHER { 12. Name **Unknown** 9

18. Birthplace **Unknown** (City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

16. (a) Informant **Lawrence C Foster**

(b) Address **Appleton City, Mo**

17. (a) **Burial** (b) Date thereof **7 29-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Montrose Mo.**

18. (a) Signature of funeral director **Oscar Eckhardt**

(b) Address **Appleton City, Mo**

19. (a) **July 27-1940** (b) **Otis Aubrey**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **27**
year **1940** hour **3** minute **30 a.m.**

21. I hereby certify that I attended the deceased from **June 24**
19**40** to **July 27** 19**40**
that I last saw him alive on **July 24** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Sclerosis**

Due to _____

Due to **9418**

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? **8310**

(Specify type of place) While at work? **WAT** (e) Means of injury _____

23. Signature **WAT** (M. D. or other) **MD**

Address **Appleton City, Mo** Date signed **7-27-40**

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

RECEIVED

District Health Officer No. 7,

District File Number 8-40-1098

Date Filed 8-7-40

RECEIVED
DISTRICT HEALTH OFFICER NO. 7
DISTRICT FILE NO. 8-40-1098
DATE FILED 8-7-40
RECEIVED
DISTRICT HEALTH OFFICER NO. 7
DISTRICT FILE NO. 8-40-1098
DATE FILED 8-7-40

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 Oscar Schlopp

Licensed Embalmer No. 3942

P. O. Address Oppton St, Minn

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26140

Registration District No. 761

Primary Registration District No. 4456

Registrar's No. _____

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

ROWENA MOORE

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Appleton City Mo.
(If outside city or town limits, write "RURAL" and name of town)

(c) Name of hospital or institution: 1st Hickory St (in Home)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. None
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Appleton City Mo.
(If outside city or town limits write "RURAL")

(d) Street No. 1st and Hickory St.
(If rural, give location)

(e) If foreign born, how long in U. S. ? _____ years.

3. (a) PRINT FULL NAME Alfred Columbus Foster

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month 7 day 27
year _____ hour _____ minute _____ M.

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced wid

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years.

Immediate cause of death _____

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

8. AGE: Years 75 Months 5 Days 10
If less than one year _____ hr. _____ min.

Due to _____

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

Due to _____

10. Usual occupation _____

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

11. Industry or business _____

Major findings: _____
Of operations _____

12. Name _____

Of autopsy _____

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 _____

(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) Jan. 14-1941 (b) Chas. Abney
(Date received local registrar) (Registrar's signature)

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. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

