No. 2
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X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FEB JAN 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41189

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4582

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: K.C.General Hospital No. 1.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community 40 yrs

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. 3007 York
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME MARY E. FOSTER
3. (b) If veteran, name war *******
3. (c) Social Security No. *******
4. Sex Femal
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Samuel M.Foster
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased Mar. 7 1876 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
64	8	23	____ hr. ____ min.

9. Birthplace ____ (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation At Home 9
11. Industry or business
FATHER 12. Name Thomas Swartz 9
13. Birthplace ____ (City, town, or county) No record (State or foreign country)
MOTHER 14. Maiden name Noreword
15. Birthplace ____ (City, town, or county) No record (State or foreign country)
16. (a) Informant Homer W.Foster
(b) Address 3007 York
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Washington
18. (a) Signature of funeral director Mrs C.L.Forster
(b) Address 918 Brooklyn
19. (a) 12-2-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30th year 1940 hour 12 minute 55 A.M.
21. I hereby certify that I attended the deceased from 11-28-40, 19__, to 11-30-40, 19__; that I last saw h er alive on 11-30-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral thrombosis	
Terminal bronchopneumonia.	
Due to 82B	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Drury R. Thom (M. D. or other)
Address General Hosp Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Theron A. Redmon

Licensed Embalmer No. 2737

P. O. Address K.C. 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.