No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10101

Registration District No. 85 APR 15 1941

Primary Registration District No. 100

Registrar's No. 297

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: Missouri Methodist 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)

In this community 22 years. 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 3307 St. Joseph Ave. (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME James Andrew Foster

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 1

5. Color or race White

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

6. (b) Name of husband or wife Carrie Foster

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased November (Month) 8, (Day) 1871 (Year)

8. AGE: Years 69 Months 4 Days 2 If less than one day ___ hr. ___ min.

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

10. Usual occupation Retired Building Contractor

11. Industry or business Building Contractor

FATHER
12. Name William B. Foster
13. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Sarah Hollowell
15. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mrs. Carrie Foster

(b) Address 3307 St. Joseph, Ave. St. Joe, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 12, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemt'

18. (a) Signature of funeral director Herman Wm Sidenfaden

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) Mar. 11, 1941 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th year 1941 hour 6 minute 30 A M.

21. I hereby certify that I attended the deceased from Apr. 7, 1940 to Mar. 10, 1941; that I last saw him alive on Mar. 9, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	1/2 hr.
Due to Arterio-sclerosis-gen.	many years
Due to Valvular heart disease (mitral)	2 yrs
Other conditions (Include pregnancy within 3 months of death): myocardial insufficiency, edema	1 month

Major findings:
Of operations none
Of autopsy none

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)

85

While at work? (e) Means of injury

23. Signature G. T. Bloomer (M. D. or other) M.D.

Address 1218 N. 3d St. Date signed 3/10/41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

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 Albert L. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, 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, fact should be so stated above.