

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

37626 *eye*

DEC 22 1941

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kaw Primary Registration District No. St. Joseph Hospital
City Kansas City, Mo. (No. St. Joseph Hospital)

File No. _____
Registered No. 4421 (Ward) 6

2. FULL NAME

(a) Residence, No. Parkville St. Mo. Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 2 1921

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 10 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER 13. NAME Matt Foster

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Maud McMillen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Mrs. John Heller (ADDRESS) Parkville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bruner Ridge DATE Nov 24 1941

19. UNDERTAKER Noland (ADDRESS) Parkville, Mo.

20. FILED 11/29 1941 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 22 1941

22. I HEREBY CERTIFY, That I attended deceased from Oct 23 1941 to Nov 22 1941

I last saw him alive on Nov 22 1941. Death is said to have occurred on the date stated above, at 5:30 a.m.

The principal cause of death and related causes of importance were as follows:

Streptococcus Septicemia
Cardiac Decompensation
Pulmonary Abscesses
Osteomyelitis

Date of onset

Other contributory causes of importance: 15467

Name of operation _____ Date of _____
What test confirmed diagnosis Blood Cultures and where an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1941

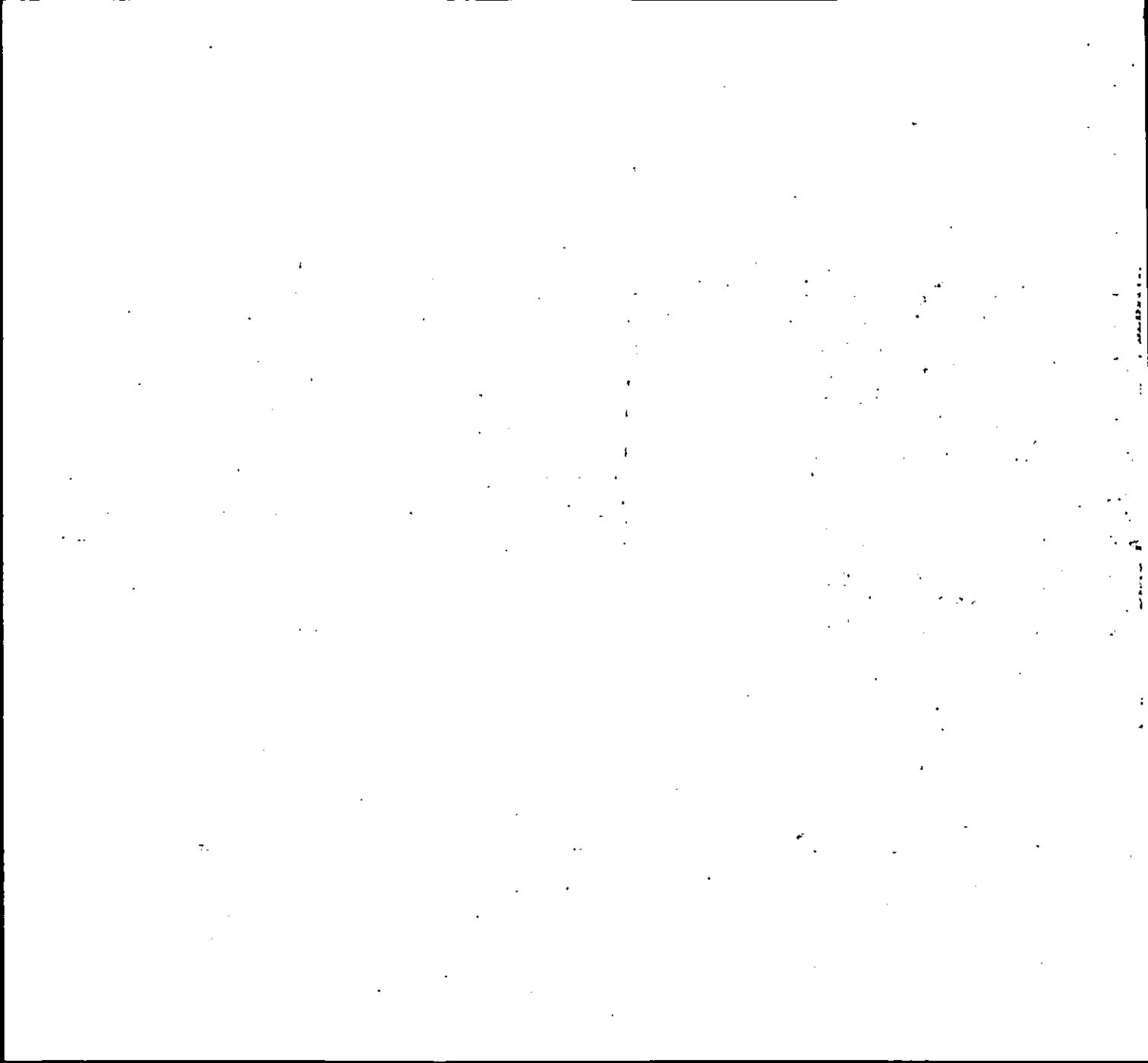
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify Hadenwood Co (Signed) _____, M. D.
Parkville, Mo. (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4421**

1. PLACE OF DEATH:

(a) County

(b) City or town

(c) Name of hospital or institution:
St. Joseph Hospital
(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)

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **James L. Foster**

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

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years

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

8. AGE: Years Months Days If less than one day
20 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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **11/29/41** (Date received local registrar) (b) **M. M. Corom** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **22**
year hour minute M.

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

Immediate cause of death:
Streptococcus Septicemia
Cardiac Decompensation
Pulmonary Abscesses
Due to: **0 steompelitis - Streptococcus**

Other conditions. (Include pregnancy within 3 months of death) **95c²**

Major findings:
Of operations

Of autopsy

Duration

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) (2) Means of injury

23. Signature **[Signature]** (M. D. or other) **MD**

Address **Wassilla, Mo.** Date signed

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

2
41
39
29484

S-37626

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.