No. 2
-1-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 24 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40831
4507

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

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town R.C.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Gen'l Hosp. No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 15 yrs. 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Kansas City 048
(If outside city or town limits, write "RURAL")
(d) Street No. 1815 Harrison 3
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME David Foster
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar. (Month) 9 (Day) 1922 (Year)

8. AGE: Years 19 Months 8 Days 15 If less than one day hr. min.

9. Birthplace Centerville (City, town, or county) Iowa (State or foreign country)
10. Usual occupation N. Y. A.
11. Industry or business
FATHER
12. Name Forrest Foster
13. Birthplace Lexington, Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Daisy Triplett
15. Birthplace Henrietta Mo. (City, town, or county) (State or foreign country)
16. (a) Informant Daisy Foster, mother
(b) Address 1017 E. 16th 3rd fl. W.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-41 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln
18. (a) Signature of funeral director Adkins Bros.
(b) Address 2000 E. 17th K.C. Mo.
19. (a) 12/5/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 4:00 a.m. to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute generalized septicemia	
Due to Gangrene of the right thigh	
Due to Amputation of right leg for traumatic injury	6
Other (Include pregnancy within 3 months of death) Railroad traumatism (169)	

Major findings:
Of operations Amputation at operation
Of autopsy Yes

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) Accident
(b) Date of occurrence 11-18-41
(c) Where did injury occur? K.C. (City or town) 123 (County) Mo (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 Arthur Miller (M. D. or other)
Address K.C. Mo. 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.....

Licensed Embalmer No.....3836

P. O. Address.....

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.