

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39270
State File No. _____
Registrar's No. 27

Registration District No. 332 Primary Registration District No. 30716 Registrar's No. 27

1. PLACE OF DEATH
(a) County Saline
(b) City or town Rural Cambridge
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 74 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) County Saline
(b) City or town Rural Cambridge
(c) Street No. _____ (If rural, give location)
(d) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Washington Foster
3. (b) If veteran; name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10 day 5 year 1943 hour 11:00 am M.
21. I hereby certify that I attended the deceased from Sept 23-43 to Oct 5 1943 that last saw him alive on Oct 4 1943 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of skin Black
6. (a) Single, widowed, married, divorced, divorced, married
6. (b) Name of husband or wife Sara Foster
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased June 1 - 1879 (Month) (Day) (Year)

Immediate cause of death Coronary occlusion
Duration _____

8. AGE: 74 years 4 months 4 days If less than one day _____ hr. _____ min.

Due to _____
Due to _____ 94a

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

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business _____

Major findings: Of operations _____

12. Name Robert Foster

Of autopsy _____

13. Birthplace Rural Cambridge Mo (City, town, or county) (State or foreign country)

14. Maiden name Sara Williams (City, town, or county) (State or foreign country)

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

16. (a) Informant Robert Foster
(b) Address _____

17. (a) My burial (b) Date thereof 10-9-43 (Month) (Day) (Year)
(c) Place: burial or cremation State Mo

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? _____

18. (a) Signature of funeral director _____
(b) Address _____

23. Signature _____ (Specify type of place) (e) M.D. or other) _____
Address _____ Date signed 10/7/43

19. (a) 10-15-43 (b) Mrs. John G. Gie (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

12-3-43

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 with the above constitutes grounds for revocation of license.)

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