DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1387

FILED FEB 28 1944

Registration District No. 1449

Primary Registration District No. 1002

Registrar's No. 40

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: 7019 E-12th Terrace

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ In this community 43 yrs (Specify whether years, months or days)

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. 7019 E. 12th Terrace

(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) No

If yes, name country ____

3. (a) PRINT FULL NAME: George A Foster

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Clara K Foster

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Aug 16 1867 (Month) (Day) (Year)

8. AGE: Years 76 Months 4 Days 16 If less than one day ____ hr. ____ min.

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

10. Usual occupation Retail Fee Salesman

11. Industry or business ____

MOTHER FATHER

12. Name John Foster

13. Birthplace no (City, town, or county) (State or foreign country)

14. Maiden name Martha

15. Birthplace no (City, town, or county) (State or foreign country)

16. (a) Informant Claude E Foster

(b) Address 7019 E-12th Terrace

17. (a) Funeral (Burial, cremation, or removal) (b) Date thereof Jan 7 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Mrs C. L. Foster

(b) Address 918 Brooklyn

19. (a) Jan 5 1944 (Date received by local registrar) (b) E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2 year 1944 hour 7 minute 0 P. M.

21. I hereby certify that I attended the deceased from Dec. 27, 1943, to Jan 2, 1944, that I last saw him alive on Jan 2, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Hemorrhage of Basilar artery — Duration 2 days

Due to: severe high blood pressure and — Duration 1 year

Due to: Hardening of arteries — Duration 1 year

Other conditions (Include pregnancy within 3 months of death): 130 very anemic

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? ____ While at work? ____ (Specify type of place) (e) Means of injury ____

23. Signature E. H. Beilinger (M. D. or other)

Address 520 Argyle Bldg. Date signed 1/4/44 K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

WHITE PLAINS — SEE OTHER 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 me

..... Registered Apprentice No. .....

working under my personal supervision.

Signed .....

Licensed Embalmer No. 25-70

P. O. Address K O [illegible]

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

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