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43
39
35897

FILED FEB 14 1944

Registration District No. 2

Primary Registration District No. 4006

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town Fillmore mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 39 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew

(c) City or town Fillmore
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME FREDRICK NORMAN FOSTER.

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Abbie O. Foster

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Oregon mo April 3 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>9</u>	<u>22</u>	hr. min.

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

10. Usual occupation Pharmacist
Drugs Retail

11. Industry or business _____

12. Name Albert J. Foster

13. Birthplace Oregon Missouri
(City, town or county) (State or foreign country)

14. Maiden name Virginia Thornhill

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

16. (a) Informant Abbie O. Foster

(b) Address Fillmore, Missouri

17. (a) Burial (b) Date thereof 1-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Savannah Cemetery

18. (a) Signature of funeral director Halter Meierhoffer

(b) Address 1302 Sarsan St. St. Joseph Mo.

19. (a) 1-27-44 (b) F.H. Fitchman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year 1944 hour 5 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct-1941
1941 to Jan 24 1944;
that I last saw him alive on Jan 24 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Congestion 10 DAYS

Due to Cardiac Failure 19 YEARS

Due to Hypertension Malignant 3 years

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____

Of autopsy not made

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)

(c) Means of injury _____

23. Signature M. L. Holliday (M. D. or other) M.D.
Address Fillmore mo Date signed 1-25-44

RECORD INK - MAKE A PERMANENT RECORD

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 E. Harrington*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Andrew

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

(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 _____ (Specify whether _____)
In this community 394 years, months or days

3. (a) PRINT FULL NAME Fredrick N. Footer

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased april 3 1908
(Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days 12 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 25 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ 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 Pulmonary Congestion
Cardiac Failure
Hypertension Malignant

Due to _____ Duration 100%
Due to _____ 1 1/2%

Other conditions (include pregnancy within 6 months of death) _____

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN [Signature]
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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTAL

1907