V. S. No. 2
00M—8-43
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24121

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 793

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 407 Bollinger Bldg
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 6 Mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 407 Bollinger Bldg.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country D

3. (a) PRINT FULL NAME Ellsworth Logan Foster
3. (b) If veteran, name war No
3. (c) Social Security No. 498-24-6715
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife ~~[illegible]~~ Iva
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Aug (Month) 11 (Day) 1879 (Year)

8. AGE: Years 64 Months 11 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace Holt Co (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation Retired Farmer
11. Industry or business
FATHER
12. Name James M Foster
13. Birthplace Holt Co (City, town, or county) Mo (State or foreign country) 0
MOTHER
14. Maiden name Adeline
15. Birthplace (City, town, or county) Ohio (State or foreign country) 1
16. (a) Informant Iva B. Foster
(b) Address St Joseph, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-29-44 (Month) (Day) (Year)
(c) Place: burial or cremation Hiawatha, Kans
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph, Mo.
19. (a) 7/29/44 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27
year 1944 hour 2 minute 26 P.M.
21. I hereby certify that I attended the deceased from 7-25-44, 1944, to 7-26, 1944
that I last saw him alive on 7-26, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to arteriosclerosis
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy no

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

8 30

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

23. Signature C. L. Ferguson (M.D. or other) D.O.
Address 801½ [illegible] Date signed 7-28-44

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(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 Robert L. Apple

Licensed Embalmer No. 3308

P. O. Address St Joseph, MO.

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.