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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24830**

FILED JUL 20 1944

Registration District No. **168**

Primary Registration District No. **5568**

Registrar's No. **168**

1. PLACE OF DEATH:

(a) County **Jackson**

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

(c) Name of hospital or institution:
1501 S. Logan Blue Jays
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1** (Specify whether)
In this community **36 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **48**

(c) City or town **Independence (Rural)** **0**
(If outside city or town limits, write "RURAL")

(d) Street No. **1501 S. Logan**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **JAMES E. FOULKS**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **none**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **27**
year **1944** hour **8** minute **45** AM.

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.

4. Sex **Male** 5. Color or race **White**

6. (a) Name of husband or wife **Mary E. Foulks**

6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **December 18 1965**
(Month) (Day) (Year)

Immediate cause of death **Cerebral Embolism** *twice*

Duration _____

8. AGE: Years **78** Months **6** Days **8** If less than one day _____ hr. _____ min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **838**

9. Birthplace **Green Co. Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Carpenter**

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name **David Foulks**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Creek**

15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant **Mrs. Mary E. Foulks**

(b) Address **1501 S. Logan, Independence, Mo.**

17. (a) **Burial** (b) Date thereof **6-30-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mound Grove**

18. (a) Signature of funeral director **George C. Carson**

(b) Address **Independence, Missouri.**

19. (a) **6-30-1944** (b) **James A. Ross**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury **2**

23. Signature **Med. Whetstone** (M. D. or other) **MO**

Address **323 W. Lexington** Date signed **6/27/44**

1113 (Licensed Embalmer's Statement on Reverse Side) Independence Mo.

WRITE PLAINLY—USE UNFADING BLACK 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

George C. Carson
.....
Licensed Embalmer No. *2249*

P. O. Address *Independence*

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.