

FILED SEP 26 1944
Registration District No. 197

Primary Registration District No. 1002

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

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: General Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution died in residence
(Specify whether) 11 yrs
In this community 11 yrs
years, months or days)

3. (a) PRINT FULL NAME Mrs Ida May Foster
3. (b) If veteran, name war. No
3. (c) Social Security No. No

4. Sex I 5. Color or race W
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Samuel Foster
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased 3 10 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 5 29 hr. min.

9. Birthplace 0 mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name James Delbey
13. Birthplace 0 mo
(City, town, or county) (State or foreign country)
14. Maiden name Anna Nichols
15. Birthplace 1 st Ia
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel Foster
(b) Address 1012 Fuller

17. (a) Burial (b) Date thereof 9-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dehany mo
18. (a) Signature of funeral director John P. Shiel
(b) Address 614 0

19. (a) 9-11-44 (b) N. E. Brown
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1012 Fuller
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Il

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 9
year 1944 hour 4 minute 25 P M.

21. I hereby certify that I attended the deceased from 19
that I last saw him Repitly Cooper alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death Spontaneous cerebral hemorrhage
Duration

Due to 83a

Other conditions 83a
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy See Above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 _____
(Specify type of place) (b) Means of injury _____
23. Signature W. E. Walker (M. D. or other) MD
Address 28 Mcay Date signed 9/11/44

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 John P. Shiel

Licensed Embalmer No. 3625

P. O. Address K 6 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.