V. S. No. 2
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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Hal 6533

State File No.

FILED FEB 16 1945

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 416

58 1 2

1. PLACE OF DEATH:
(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 13 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Linn 58 1
(c) City or town Brookfield Mo 2
(If outside city or town limits, write "RURAL")
(d) Street No. 518 N. Livingston
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JOSEPH ROBERT FOSTER
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M O
5. Color or race Lt
6. (a) Single, widowed, married, divorced M 1
6. (b) Name of husband or wife Ella Foster
6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased Mar (Month) - 19 (Day) - 1859 (Year)

8. AGE:

Years	Months	Days	If less than one day
85	10	3	hr. min.

9. Birthplace Davisbo (City, town, or county) Mo. (State or foreign country) A
10. Usual occupation
11. Industry or business Farmer
FATHER
12. Name Robert Foster
13. Birthplace (City, town, or county) Va (State or foreign country) 1
MOTHER
14. Maiden name Jane Walls
15. Birthplace (City, town, or county) D.K. (State or foreign country) D.K. 1
16. (a) Informant Ella Foster
(b) Address Brookfield Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan (Month) - 24 (Day) - 1945 (Year)
(c) Place: burial or cremation Jamesport Missouri
18. (a) Signature of funeral director Hill Funeral Home
(b) Address Brookfield Mo
19. (a) 1-25-1945 (Date received local registrar) (b) W H Cannon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22
year 1945 hour 11 minute 45 P M.
21. I hereby certify that I attended the deceased from Sept 25, 1944, to Jan 22, 1945;
that I last saw him alive on Jan 22, 1945;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death General Arterio-sclerosis	8 yrs
Due to Congestive Heart Disease & Myocarditis	6 mo
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Roy R Taley (M. D. or other) MD
Address Brookfield Mo Date signed 1-23-45

906

(Licensed Embalmer's Statement on Reverse Side)

FEB 11 [illegible]

8 01 [illegible]

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 J. W. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield 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.