

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40096**
Registrar's No. **5177**

FILED JAN 9 1946
Registration District No. **197**

Primary Registration District No. **1002**

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

48
3
8

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:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 day**
 In this community **3 yrs.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Gladys Foster**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **none**

4. Sex **F**
 5. Color or race **whit**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Francis M. Foster**
 6. (c) Age of husband or wife if alive **32** years
 7. Birth date of deceased **June 10, 1914**
(Month) (Day) (Year)

8. AGE:
 Years **31** Months **6** Days **5**
 If less than one day hr. min.

9. Birthplace **Keystonville, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

12. Name **Gasper Hayes**

13. Birthplace **Keystonville, Mo**
(City, town or county) (State or foreign country)

14. Maiden name **Ella Hayes**

15. Birthplace **Keystonville, Mo**
(City, town or county) (State or foreign country)

16. (a) Informant **Francis Foster**

(b) Address **18201 Wilson Rd. K.C. Mo**

17. (a) **Removal** (b) Date thereof **12/17/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Keith Keystonville, Mo**

18. (a) Signature of funeral director **Colandrea**

(b) Address **Independence, Mo**

19. (a) **12-17-45** (b) **Geraldine Tolme**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
 (d) Street No. **8201 Wilson Road**
(If rural, give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Dec.** day **15th**
 year **1945** hour **12** minute **20 P.** M.

21. I hereby certify that I attended the deceased from **12-14-45**, 19, to **12-15-45**, 19,
 that I last saw her alive on **12-15-45**, 19,
 and that death occurred on the date and hour stated above.

Immediate cause of death **Rupture of uterus**
 Duration

Due to
 Due to **full term death after delivery**

Other conditions (Include pregnancy within 3 months of death) **149a**

Major findings: **Caesarean Section**
 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:

(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 **Clark W. Seel** (M. D. or other)
 Address **Med. Dir. K.C. Gen. Hospital**

801

FEB 18 1946

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.....

Roland P. Speaks

Licensed Embalmer No. *3604*

P. O. Address *Indep 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.