S. No. 2
0M—2-43
v. 5-17-39
1 X35697

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

967

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1367

FILED FEB 7 1946

State File No.

Registration District No. 147

Primary Registration District No. 1002

Registrar's No. 323

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days (Specify whether years, months or days)
In this community 5 yrs.

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. 824 E. 24th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jennie Foster
3. (b) If veteran, name war No
3. (c) Social Security No. none
4. Sex Female
5. Color or race Colored
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 8 (Month) 10 (Day) 1882 (Year)
8. AGE: Years 63 Months 5 Days 9 If less than one day hr. min.
9. Birthplace unknown (City, town, or county) (State or foreign country)
10. Usual occupation Porter
11. Industry or business
MOTHER FATHER
12. Name Robert Foster
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Nancy Green
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Hospital Rec
(b) Address Hosp #2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Marshall Chapel
18. (a) Signature of funeral director J. D. Ferguson
(b) Address Sedalia Mo
19. (a) 1-20-46 (Date received by local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19 year 46 hour 11 minute 30 P.M.
21. I hereby certify that I attended the deceased from January 4 1946 to Jan 19 1946 that I last saw him alive on January 18 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Cardiac Failure	
Due to: Luetic Heart Disease	1 yr
Due to:	
Other conditions: Renal Failure (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 30 M

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 Dr. P. C. Turner / C. D. Ellis (M. D.)
Address Veterans Hosp. No. 2 Date signed 1/21/46

(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 F. D. Ferguson

Licensed Embalmer No. 2172

P. O. Address Sedalia

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.