

FILED APR 23 1947

STANDARD CERTIFICATE OF DEATH

State File No.

1662

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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 No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
 (Specify whether
 In this community 15 yrs
 years, months or days)

3. (a) PRINT
FULL NAMEAudrey Foster

3. (b) If veteran,

name war

No

3. (c) Social Security

No

none

4. Sex Fe 5. Color or race W
 6. (a) Single, widowed, married, divorced Widowed
 6. (c) Age of husband or wife if
Charles A. Foster alive _____ years
 7. Birth date of deceased Jan 13 1894
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 2 28 _____ hr. _____ min.

9. Birthplace Rutherford Tenn.
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name R. H. Arnold
 13. Birthplace (Unknown)
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Bell
 15. Birthplace (Unknown)
 (City, town, or county) (State or foreign country)

16. (a) Informant Betty Wechsler

(b) Address 4801 Roanoke, K.C. Mo.

17. (a) Burial (b) Date thereof 4/14/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director J. P. Lewis Funeral Home

(b) Address 3400 Woodland K.C. Mo.

19. (a) 4-12-47 (b) Thelma Holmes
 (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. 4801 Roanoke Pkwy.
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
 year 1947 hour 9 minute 15 P.A.M.

21. I hereby certify that I attended the deceased from
April 9 1947 to April 11 1947
 that I last saw h. er alive on April 11 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary tuberculosis with acute congestive heart failure

Duration

Due to _____

Due to _____

Other conditions 13/8
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy None

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature Wm W. Hart (M. D. or other) MA
 Address Med. Dir. Gen'l Hosp. Date signed 4-12-47

A. J. Taylor

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..... *A. L. Louis*.....

Licensed Embalmer No..... *3110*.....

P. O. Address..... *K. C. 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.

FILED MAY 12 1947

Registration District No. *149*

Primary Registration District No. *1002*

Registrar's No. *1662*

1. PLACE OF DEATH

(a) County *Jackson*
(b) City or town *N.C.*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME *Andrey Boster*
(b) If veteran, name war. (c) Social Security No.

4. Sex _____ race _____
5. Color or _____
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased *January 13 1929*
(Month) (Day) (Year)
8. AGE: Years *53* Months *2* Days *0* If less than one day _____ hr. _____ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) *4-12-47* (b) *Steraldine Helms*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *April* Day _____ Year *1947* Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____

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?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

COPY ON OTHER SIDE OF THIS PAPER - MAKE A PERMANENT RECORD

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