S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 7 1947

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 35726
Registrar's No. 9932

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 520 N. Union Vitamin and Trout Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 6 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County 000
(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 520 N Union appt 807 9
(If rural, give location)
(e) Citizen of foreign country? 12 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Morris Foster
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife Mary Foster
6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased Unknown (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| About | 64 | — | — | — hr. — min. |

9. Birthplace Ushomir (City, town, or county) Russia (State or foreign country) 6
10. Usual occupation Hosiery. Merchant
11. Industry or business
FATHER
12. Name Abraham Josha Foster
13. Birthplace (City, town, or county) Russia (State or foreign country) 6
MOTHER
14. Maiden name Rachel P.
15. Birthplace (City, town, or county) Russia (State or foreign country) 6
16. (a) Informant Dr Theon Foster
(b) Address Embassy Apartment
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-28-47 (Month) (Day) (Year)
(c) Place: burial or cremation Savannah Gar.
18. (a) Signature of funeral director Henhardin
(b) Address 5010 Enright
19. (a) OCT 28 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 27
year 1947 hour 4 minute 00 P. M.

21. I hereby certify that I attended the deceased from May, 1947, to Oct. 27, 1947
that I last saw him alive on Oct. 27, 1947
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Coronary artery disease | years |
| Due to: Arteriosclerosis | years |
| Due to: Hypertensive heart disease | years |

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 0

23. Signature M. S. Franklin (M. D. or other)
Address 634 N. Grand Date signed 10/27/47

Jefferson City Printing Co. (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 J B Oxenhandler

Licensed Embalmer No. 3669

P. O. Address 5010 Enright

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.