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 JAN 10 1948

Registration District No. 297

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 43799

Registrar's No. 2735

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Jefferson Barracks, Missouri (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 Day (Specify whether years, months or days)
In this community: 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 020
(c) City or town: St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No.: 1610 Gay Street (If rural, give location) 9
(e) Citizen of foreign country? - (Yes or No) 1
If yes, name country: -

3. (a) PRINT FULL NAME: FOSTER, Isom
3. (b) If veteran, name war: WW-1
3. (c) Social Security No.: Unknown
4. Sex: Male 2
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Widowed 2
6. (b) Name of husband or wife: Gertrude
6. (c) Age of husband or wife if alive: - years
7. Birth date of deceased: January (Month) 1 (Day) 1889 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 11 | 24 | hr. min. |

9. Birthplace: Arcadia, Louisiana (City, town, or county) (State or foreign country) 1
10. Usual occupation: None
11. Industry or business:
FATHER 12. Name: ~~XXXXXXXXXX~~ Unknown
13. Birthplace: (City, town, or county) (State or foreign country) 7
MOTHER 14. Maiden name: Gussie ( unknown)
15. Birthplace: Louisiana (City, town, or county) (State or foreign country) 1
16. (a) Informant: Registrar
(b) Address: VAH, Jeffefson Barracks, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-31-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Nat'l Cem. Jeff. Bks. Mo.
18. (a) Signature of funeral director: Gates Funeral Home
(b) Address: 4107 Finney, St. Louis, Mo.
19. (a) 12-31-47 (Date received local registrar) (b) Cecil Gates (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: December day: 25 year: 1947 hour: 1:20 minute: P. M.
21. I hereby certify that I attended the deceased from December 24, 1947, to December 25, 1947; that I last saw him alive on December 25, 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: CARCINOMA, RECURRENT, OR RECTUM | Unknown |
| Due to: - | |
| Due to: - | |
| Other conditions: - (Include pregnancy within 3 months of death) | |
| Major findings: Of operations: - | |
| Of autopsy: No Autopsy performed | |

46d

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: L. E. Libey (M. D. or other)
Address: Jeff. Brks. Date signed: 12/26/47

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 Thomas J. Gates Registered Apprentice No. working under my personal supervision.

Signed Thos J Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

**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.