No. 300
I—10-47
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 4 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32888

Registration District No. 149 | Primary Registration District No. 1002 | Registrar's No. 4163

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 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days (Specify whether years, months or days)
In this community 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 48
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 821 E. 9 St.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Samuel R. Foster
3. (b) If veteran, name war: No
3. (c) Social Security No.: 499-10-2121
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Ida Ethel Foster
6. (c) Age of husband or wife if alive: 52 years
7. Birth date of deceased: Jul. 14, 1893 (Month) (Day) (Year)
8. AGE: Years 55 | Months 2 | Days 27 | If less than one day hr. min.
9. Birthplace (City, town, or county): Missouri 0 (State or foreign country)
10. Usual occupation: Maintainence man
11. Industry or business: Astor Hotel
FATHER 12. Name: Thomas Foster
13. Birthplace (City, town, or county): No reword 9 (State or foreign country)
MOTHER 14. Maiden name: Susan Williams
15. Birthplace (City, town, or county): No record 9 (State or foreign country)
16. (a) Informant: Ida Ethel Foster
(b) Address: 707 East 9 St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Washington
18. (a) Signature of funeral director: Mrs C. L. Forster
(b) Address: 918 Brooklyn
19. (a) 10-13-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 11 year 1948 hour 4 minute P. M.
21. I hereby certify that I attended the deceased from Sept. 25, 1948, to Oct. 11, 1948, that I last saw him alive on Oct. 11, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Silicosis	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 114a	
Major findings: 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) 0
While at work? Wm. W. (e) Means of injury: Hart
23. Signature: Wm. W. Hart (M. D. or other)
Address: Med. Dir. Gen'l Hosp. Date signed: 10-12-48

(Licensed Embalmer's Statement on Reverse Side)

Dr. Riemann

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 Joe B. Yoder

Licensed Embalmer No. 4173

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.