

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **39512**

FILED DEC 29 1948

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **389** PRIMARY REG. DIST. NO. **5145** Registrar's No. **27**

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Guthrie</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Guthrie Mo</b>	
c. LENGTH OF STAY (In this place) <b>life</b>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Richard Payne</b> b. (Middle) <b>Foster</b> c. (Last) <b>Foster</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 23 - 48</b>		
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5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>Mar-17-1871</b>		9. AGE (In years last birthday) <b>77</b> if UNDER 1 YEAR Months <b>9</b> Days <b>6</b> if UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-R</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Callaway Co. Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>John M. Foster</b>		13b. MOTHER'S MAIDEN NAME <b>Lucy Wilson</b>		14. NAME OF HUSBAND OR WIFE	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Miss Lucy Foster</b> ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. <b>466</b>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Gland Prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>1940</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Gland Prostate</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
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22. I hereby certify that I attended the deceased from **Jan 1945**, to **Dec 23, 1948**, that I last saw the deceased alive on **Dec 22, 1948**, and that death occurred at **5:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>P. McDonald MD</b> (Degree or title)		23b. ADDRESS <b>New Bloomfield Mo</b>		23c. DATE SIGNED <b>Dec 24 48</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Dec 24 - 48</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Day York Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>2 mi west Guthrie</b>	
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DATE REC'D BY LOCAL REG. <b>12/24/48</b>		REGISTRAR'S SIGNATURE <b>LeRoy Clayton</b>		FUNERAL DIRECTOR'S SIGNATURE <b>Walter Clayton Sr.</b> ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number

DEC 28 1948

Date Filed

JAN 5 1949

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*LeRoy Claypool*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*4412*

P. O. Address \_\_\_\_\_

*New Bloomfield 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.