

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9100

5800

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

BIRTH NO. _____		REG. DIST. NO. <u>185</u>		PRIMARY REG. DIST. NO. <u>4300</u>		Registrar's No. <u>7</u>		
1. PLACE OF DEATH a. COUNTY <u>Linn</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission?) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>					
b. CITY OR TOWN <u>Laclede</u>		c. LENGTH OF STAY (In this place) <u>24 yrs</u>	c. CITY OR TOWN <u>Laclede</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			d. STREET ADDRESS (If rural, give location) <u>0</u>					
3. NAME OF DECEASED (Type or Print) <u>ANDREW JACKSON FOSTER</u>			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH <u>3-12-49</u>			(Month)		(Day)		(Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2-15-1873</u>		9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>27</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>John W. Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Hester Graves</u>		14. NAME OF HUSBAND OR WIFE <u>Hancy Jane</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. A. J. Foster, Laclede, Mo.</u> ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>One day</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis with occlusion</u>			DUE TO (b) <u>Arteriosclerosis</u>					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			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 _____		19b. MAJOR FINDINGS OF OPERATION <u>4"</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>March 12</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Mar. 11</u> , 19 <u>49</u> , and that death occurred at <u>12:00 P.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>John R. Dufur M.D.</u> (Degree or title)				23b. ADDRESS <u>Brookfield Mo</u>		23c. DATE SIGNED <u>3-14-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-14-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Laclede</u>		24d. LOCATION (City, town, or county) <u>Laclede Missouri</u> (State) _____			
DATE REC'D BY LOCAL REG. <u>Mar. 14-1949</u>		REGISTRAR'S SIGNATURE <u>Chris A. Martens</u> 169		25. FUNERAL DIRECTOR'S SIGNATURE <u>Brother Funeral Home, Laclede Mo</u> ADDRESS _____				

MAR 30 1949

MAR 30 1949

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.

Student
Student Embalmer

Signed *W.R. Wright*

Licensed Embalmer No. *4655*

P. O. Address *Leaside, 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.