

No. 300
10-48

FILED APR 15 1949

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10049**
3137

BIRTH NO. **49-024572** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1004** Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SX Louis 15		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN East St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		d. STREET ADDRESS (If rural, give location) RR # 5 Ridge Heights	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Thomas Richard Foster		April 6 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH April 4 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) SX Louis 151 Mo	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? yes	

13a. FATHER'S NAME Thomas Foster	13b. MOTHER'S MAIDEN NAME Kwma L Loescher	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs T S Foster RR # 5 Ridge Heights
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		18. CAUSE OF DEATH (continued)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspirational pneumonia		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) Prolonged labor		
DUE TO (c) marginal placenta / 1st		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7 1/2

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE John J. Bernwald M.D.	23b. ADDRESS 4150 N. Newstead	23c. DATE SIGNED 4-6-49
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 4-7-49	24c. NAME OF CEMETERY OR CREMATORY UNION MINERS	24d. LOCATION (City, town, or county) (State) MT. OLIVE ILL.
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DATE RECORDED BY LOCAL HEALTH DEPT.	REGISTRAR'S SIGNATURE J. B. Rosater	25. FUNERAL DIRECTOR'S SIGNATURE M. C. Becker	ADDRESS 4 Mt. Olive, Ill.
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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 _____

INFANT NOT EMBALMED

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed M. C. Becker

Licensed Embalmer No. 2700

P. O. Address M. Olive, Ill

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.