

FILED JUL 10 1950

STANDARD CERTIFICATE OF DEATH

State File No. 20737

51

BIRTH NO. _____ REG. DIST. NO. 164 PRIMARY REG. DIST. NO. 3032 Registrar's No. 86

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

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrensburg</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Davis Township 054</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Warrensburg Hospital & Clinic, Inc.</u>		d. STREET ADDRESS (If rural, give location) <u>B. H. # 4 Higgenville</u>	

3. NAME OF DECEASED (Type or Print) <u>Charles Lester Foulds</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 25 1950</u>		
a. (First)	b. (Middle)	c. (Last)			
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>Dec. 11, 1880</u>	9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days
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>Owner of Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Higgenville, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					

13a. FATHER'S NAME <u>George Foulds</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Pool</u>		14. NAME OF HUSBAND OR WIFE <u>Virginia Nash Foulds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>George Foulds, St. Louis, Missouri</u>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
		* ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>			
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>3327</u>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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 June 17, 1950, to June 25, 1950, that I last saw the deceased alive on June 25, 1950, and that death occurred at 4:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Katherine M. O.</u>		23b. ADDRESS <u>Warrensburg Mo</u>		23c. DATE SIGNED <u>June 26, 1950</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>June 27, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Odessa Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Odessa, Missouri</u>	

DATE REC'D BY LOCAL REG. <u>June 26, 1950</u>		REGISTRAR'S SIGNATURE <u>Sarah Ann Crutchfield</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. P. Mierckhagen Higgenville</u>	
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RECEIVED
JUL 3 1980
RECEIVED
JOHNSON COUNTY HEALTH DEPT.

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. Meinershagen* _____

Licensed Embalmer No. *1095* _____

P. O. Address *Higginsville, 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.