

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37023**
4943
Registrar's No. _____

FILED DEC 9 1950

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

3008
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 2 yrs			
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2		d. STREET ADDRESS (If rural, give location) 1306 Olive Street	

3. NAME OF DECEASED (Type or Print) ALBERT	a. (First)	b. (Middle)	c. (Last) FOSTER	4. DATE OF DEATH NOVEMBER 14 1950	(Month) (Day) (Year)
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 5 1890	9. AGE (In years last birthday) 60	# UNDER 1 YEAR Months	# UNDER 24 HOURS Hours	# UNDER 5 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) ALEXANDRIA, VIRGINIA	12. CITIZEN OF WHAT COUNTRY? NONE
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13a. FATHER'S NAME LOUIS FOSTER	13b. MOTHER'S MAIDEN NAME ISABELLE	14. NAME OF HUSBAND OR WIFE MOLLY FOSTER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNK	16. SOCIAL SECURITY NO. UNK	17. INFORMANT'S SIGNATURE OR NAME Hospital Records K. C. Mo.	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CHRONIC MYELOGENOUS LEUKEMIA		INTERVAL BETWEEN ONSET AND DEATH 204!
	ANTECEDENT CAUSES Morbidity 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	19b. MAJOR FINDINGS OF OPERATION	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 11-70, 19 50 to 11-14, 19 50, that I last saw the deceased alive on 11-14, 19 50 and that death occurred at 5:05P m., from the causes and on the date stated above.

23a. SIGNATURE Frank Ellis MD.	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 11-15-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-24-50	24c. NAME OF CEMETERY OR CREMATORY University of K. C.	24d. LOCATION (City, town, or county) (State) 10th Street - K. C. Mo.
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DATE REC'D BY LOCAL REG. 11-24-50	REGISTRAR'S SIGNATURE Sheraldine Holmes Brigham	25. FEDERAL DIRECTOR'S SIGNATURE J. H. Home	ADDRESS 2300 E. 11th
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Laurence A. Jones

Signed.....
Student Embalmer

Licensed Embalmer No. *4429*

P. O. Address *A 300 E. 18th St. - 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.