

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

36366

State File No.

FILED NOV 14 1952

9176

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY _____ | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson | |
| c. LENGTH OF STAY (In this place) 8 days | | d. STREET ADDRESS (If rural, give location) 37 Alameda Place | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hosp. | | | |

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|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) C. c. (Last) Foote | | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 3, 1952 | | |
|--|--|--|---|--|--|

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|---------------------------|-------------------------------------|---|--|--|---|--|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct. 5, 1890 | 9. AGE (In years last birthday) 61 yrs | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 4 HRS. Hours _____ Min. _____ |
|---------------------------|-------------------------------------|---|--|--|---|--|

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|--|--|--|--|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work <i>when during most of working life, or until retired</i>) Insurance broker | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (State or foreign country) Sligo Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
|--|--|--|--|--|--|---|--|

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME Emerson Lei Foote | | 13b. MOTHER'S MAIDEN NAME Julia Chase | | 14. NAME OF HUSBAND OR WIFE Elizabeth | |
|---|--|--|--|--|--|

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|--|--|---|--|--|--|-------------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. (If any, give war or dates of service) 498-26-9458 | | 17. INFORMANT'S SIGNATURE OR NAME Elizabeth Foote | | ADDRESS 37 Alameda | |
|--|--|---|--|--|--|-------------------------------------|--|

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|---|--|---|--|---|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ | | Chronic uremia | | | | 3 mos | |
| * This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES | | DUE TO (b) Carcinoma of prostate | | | |
| | | | | DUE TO (c) Ca. of Bladder | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS | | metastasis to liver | | | |
| | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|-------------------------------|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION none done | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____ | |
|---|--|---|--|---|--|

| | | | | | |
|--|--|--|--|--|--|
| 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? 181X | |
|--|--|--|--|--|--|

22. I hereby certify that I attended the deceased from 1-2-1952, to date, 19____, that I last saw the deceased alive on 9-28-1952, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

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|---|--|---|--|---|--|
| 23a. SIGNATURE <i>[Signature]</i> | | 23b. ADDRESS 3720 Worland Ave. | | 23c. DATE SIGNED 10-3-52 | |
|---|--|---|--|---|--|

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|---|--|---|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Crementation | | 24b. DATE Oct. 3, 1952 | | 24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory | | 24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | |
|---|--|---|--|---|--|---|--|

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|--|--|--|--|---|--|--------------------------------------|--|
| DATE REC'D BY LOCAL REG. OCT 3 1952 | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> | | ADDRESS 6175 Delmar | |
|--|--|--|--|---|--|--------------------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. J. Byron Bease
Beaumont Bldg
1-3

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.....

Jos. E. McCulloch

Licensed Embalmer No. 2460

P. O. Address 6175 Dellmar

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.