

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

State File No. **15693**  
Registrar's No. **4405**

FILED MAY 14 1953

**318**

**1003**

No. 300  
10.48

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Wayne</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mill Springs - 1110</u>				
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Louis Children's Hosp.</u>				d. STREET ADDRESS (If rural, give location) _____				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Brenda</u> b. (Middle) <u>Gene</u> c. (Last) <u>Foster</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>4 - 28 - 53</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>10-21-52</u>	9. AGE (In years last birthday) <u>7</u>	IF UNDER 1 YEAR Months <u>7</u>	IF UNDER 1 YEAR Days <u>7</u>	IF UNDER 24 HRS. Hours <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Mill Springs, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Leonard Allen Foster</u>			13b. MOTHER'S MAIDEN NAME <u>Opal Dougherty</u>		14. NAME OF HUSBAND OR WIFE <u>None</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. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>E. Johnston 500 S. Kings Highway</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, asthma, etc. It means the disease, injury, or complication which caused death.				<b>MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>pneumococcal meningitis</u>								
ANTECEDENT CAUSES Morbid 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 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? <u>3401</u>				
22. I hereby certify that I attended the deceased from <u>4-26</u> , 1953, to <u>4-28</u> , 1953, that I last saw the deceased alive on <u>4-28</u> , 1953, and that death occurred at <u>2:15 p.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>E. Johnston M.D.</u> (Degree or title)				23b. ADDRESS <u>Children's Hospital</u>		23c. DATE SIGNED <u>APR 29 1953</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>4-29-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Piedmont, Mo.</u>		24d. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG. <u>APR 29 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

*John J. Kainer*  
Licensed Embalmer No. 4108

P. O. Address \_\_\_\_\_

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.