

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10736

State File No.

FILED APR 4 1955

BIRTH NO. _____ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4516 Registrar's No. 22

1. PLACE OF DEATH
a. COUNTY Sullivan 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Mo b. COUNTY Sullivan

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Milan c. LENGTH OF STAY (in this place) 6 mo. c. CITY OR TOWN Harris d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION S. C. M. Hospital 11. STREET ADDRESS (If rural, give location) 3 mile South

3. NAME OF DECEASED a. (First) MARY b. (Middle) ADELINE c. (Last) FOSTER 4. DATE OF DEATH (Month) (Day) (Year) 3-29-1955

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 8. DATE OF BIRTH 3-17-1861 9. AGE (In years last birthday) 94 10. UNDER 1 YEAR Months 0 Days 0 11. UNDER 4 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Iowa 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Hays 13b. MOTHER'S MAIDEN NAME Ellen Baker 14. NAME OF HUSBAND, OR WIFE Frank Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. 2 17. INFORMANT'S SIGNATURE OR NAME Roy Foster ADDRESS Asquod Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic myocarditis INTERVAL BETWEEN ONSET AND DEATH 5 yrs
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis 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 NO

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) 4221

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 4/1, 1955, to 3/29, 1955, that I last saw the deceased alive on 3/29, 1955, and that death occurred at 4:42 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Wise, M.D. 23b. ADDRESS Harris Mo. 23c. DATE SIGNED 3/30/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 3-31-1955 24c. NAME OF CEMETERY OR CREMATORY Winterville Cem 24d. LOCATION (City, town, or county) (State) Harris Mo

DATE REC'D BY LOCAL REG. 4-1-1955 REGISTRAR'S SIGNATURE Mrs. H. B. Harris 25. FUNERAL DIRECTOR'S SIGNATURE P. A. Paynter ADDRESS Galt Mo

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

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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *PK Payne Jr*

Licensed Embalmer No. *340*

P. O. Address..... *Galt*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.