

FILED AUG 30 1955

STANDARD CERTIFICATE OF DEATH

State File No. 28854

BIRTH NO.		REG. DIST. NO. 374		PRIMARY REG. DIST. NO. 6275		Registrar's No. 39	
1. PLACE OF DEATH a. COUNTY Worth				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Worth			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Smith Rural 6275)		c. LENGTH OF STAY (in this place) 14 yrs.		c. CITY OR TOWN Rural - Smith 6275		d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒	
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location) 1130			
3. NAME OF DECEASED (Type or Print) a. (First) Comodore		b. (Middle) Clark		c. (Last) Foland		4. DATE OF DEATH (Month) (Day) (Year) August 9, 1955	
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH August 24, 1889	
9. AGE (in years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) Worth County, Missouri 0		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm			
13a. FATHER'S NAME John Foland		13b. MOTHER'S MAIDEN NAME Virginia Sharp		14. NAME OF HUSBAND OR WIFE Alice M. Foland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 497-40-6851		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Alice M. Foland - Mt. Ayr, Iowa			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic carcinoma/bladder 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.				INTERVAL BETWEEN ONSET AND DEATH 3yrs	
19a. DATE OF OPERATION 1954		19b. MAJOR FINDINGS OF OPERATION same				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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>1954</u> , to <u>Aug 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 9</u> , 19 <u>55</u> , and that death occurred at <u>4 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE Frank B. [Signature] (Degree or title) MD				23b. ADDRESS Grant City, Mo		23c. DATE SIGNED 8-11-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE August 11, 1955		24c. NAME OF CEMETERY OR CREMATORY Grant City Cemetery		24d. LOCATION (City, town, or county) (State) Grant City, Missouri	
DATE REC'D BY LOCAL REG. 8-27-1955		REGISTRAR'S SIGNATURE Edna E. Lawrence		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bill A. Dwyer - Grant City, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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 Bill A. Dunfee
Licensed Embalmer No. 490

P. O. Address Grant City

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.