

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

30702

FILED OCT 3 1956

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3974

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> COUNTY <b>Johnson</b> <b>W. Y. and Co.</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> <b>0</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b> <b>8150 S</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital</b>			Length of stay in lb <b>1 mo 17 days</b>		d. STREET ADDRESS <b>1019 So. 46th Terrace</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>F.</b> Last <b>Foster</b>				4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>1956</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-95</b>	9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <b>Policeman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>City Government</b>		11. BIRTHPLACE (City and state or country) <b>Warsaw, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Perry Foster</b>				14. MOTHER'S MAIDEN NAME <b>K.</b> <b>Bell Foster</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>510 05 0815</b>		17. INFORMANT <b>VA Hospital Records</b> Address _____					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY <b>removal</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung with widespred metastasis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr ?</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____				DUE TO (c) _____		<b>16 2 1/2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART-I(a). <b>Bronchopneumonia</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. <del>Attended the deceased from</del> <b>VA</b> <del>to</del> <b>7-20-56</b> <del>to</del> <b>9-7-56</b> <b>death occurred at</b> <del>xxxxxx</del> <b>6:45pm</b> <del>on the date stated above; and to the best of my knowledge, from the causes stated.</del>									
22a. SIGNATURE <b>Marion Lambert</b> (Degree or title) <b>0</b>				22b. ADDRESS <b>VA Hospital, K. C. Mo</b>			22c. DATE SIGNED <b>9-8-56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Sept 10-56</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hill</b>		23d. LOCATION (City, town, or county) <b>Kansas City</b>		(State) <b>Kansas</b>	
24. FUNERAL DIRECTOR <b>Joe a Buttle's Sons K.C.K.</b> ADDRESS _____				25. DATE RECD. BY LOCAL REG. <b>9-10-56</b>		26. REGISTRAR'S SIGNATURE <b>reva minshall</b>			

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

Student .....  
Signature of Student Embalmer

Signed *Jack E. Moore* .....

Licensed Embalmer No. *472*

P. O. Address *N.C.M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E 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.