

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12174

STATE FILE NUMBER

438

FILED APR 29 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN St. Joseph Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph 0117 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b HOSPITAL OR INSTITUTE Osteopathic General Hosp. 35 years		d. STREET ADDRESS (If outside, give location) Reside on Farm 307 S. 9th St. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last IRA BYRD FOSTER			4. DATE OF DEATH Month Day Year April 15, 1957		
5. SEX <input type="checkbox"/> male <input checked="" type="checkbox"/>	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1873	9. AGE (In years last birthday) 85 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor		10b. KIND OF BUSINESS OR INDUSTRY Real Estate Co.		11. BIRTHPLACE (City and state or country) Oregon, Missouri	
13. FATHER'S NAME James Foster			14. MOTHER'S MAIDEN NAME Ida Kennedy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Dr. Aurel Foster, 307 S. 9th St. St. Joseph, Mo.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO (b) Chronic Nephritis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 592X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <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. I attended the deceased from 4-11-57 to 4-15-57 and last saw ^{her} him alive on 4-14-57
Death occurred at 6:40 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. L. Requa, M.D.		22b. ADDRESS 80 1/2 Main City		22c. DATE SIGNED 4-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4/17/1957	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	

24. FUNERAL DIRECTOR Heaton-Bowmer	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. April 23, 1957	26. REGISTRAR'S SIGNATURE Kathleen M. Allison	
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(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare & Public Service
 300 1-56 0
 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
 MEDICAL CERTIFICATION
 20

file for record
8011-11-11-11

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 *James H. Hawkins*

Licensed Embalmer No. 453

P. O. Address 3190 10th St. J.

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.