

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39207

STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Boone</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Centralia</b>		a. STATE <b>Mo.</b>		b. COUNTY <b>Boone</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Centralia, Mo.</b>		Length of stay in lb <b>14 years</b>		c. CITY OR TOWN <b>Centralia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>James</b>		Middle <b>Morgan</b>		Last <b>Foster</b>		Month <b>Nov.</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</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>Sept. 24, 1891</b>	
9. AGE (In years last birthday) <b>66</b>		10. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and state or country) <b>Calhoun County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				13. FATHER'S NAME <b>Jos eph Thomas Foster</b>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Cora Wright</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs. Isabelle Foster, Centralia, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>-Hypertensive Heart Disease</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) <b>Arteriosclerosis</b>							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 _____ 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. I attended the deceased from <b>October 15, 1957</b> and last saw <del>him</del> <sup>her</sup> alive on <b>11/8/57</b> Death occurred at <b>6 p.m.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree of title) <b>C. F. Stauffer D.D.</b>			22b. ADDRESS <b>121 N. Allen Centralia Mo.</b>			22c. DATE SIGNED <b>Nov 10, 1957</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Nov. 10, '57</b>		<b>City of Centralia</b>		<b>Centralia Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Bill Meade Centralia Missouri</b>			25. DATE RECD. BY LOCAL REG. <b>Nov. 10 - 1957</b>		26. REGISTRAR'S SIGNATURE <b>Maud M<sup>rs</sup> Bride</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

S. 300  
v. 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.

Securing the medical certificate in the appropriate manner required by 193.140 MoRS 1949.

(Licensed Embalmer's Statement on Reverse Side)

NOV 19 1957

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

Signature *Bill J. Madala* ..... Licensed Embalmer No. 4872

P. O. Address *Central, Ill.*

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.