Health, Welfare Public Service
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FILED NOV 26 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-043011
STATE FILE NUMBER

Registration District No. 347 Primary Registration District No. 6172 Registrar's No. 62

1. PLACE OF DEATH
a. COUNTY Stone
b. CITY OR TOWN Washington — Inside Limits Yes ☐ No ☑
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Stone
c. CITY OR TOWN Cape Fair 1040 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First George Middle Wiley Last Foster
4. DATE OF DEATH Month Nov. Day 10 Year 1958
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 13-1898
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR Months 9 Days 27 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) River guide
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Cape Fair, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Jim Foster
13b. MOTHER'S MAIDEN NAME Julia Blankenship
14. NAME OF HUSBAND OR WIFE Sarah Foster
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 499-18-7440
17. INFORMANT Address Mrs. Sarah Foster- Cape Fair, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH Instant
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 _____, to _____ and last saw her/him alive on _____
Death occurred at 12:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. Yancey Amer Osteo Ass
22b. ADDRESS Warrenton Mo
22c. DATE SIGNED 22 Nov 1958

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Nov. 13-1958
23c. NAME OF CEMETERY OR CREMATORY Cape Fair Cemetery
23d. LOCATION (City, town, or county) (State) Cape Fair - Mo.

24. FUNERAL DIRECTOR Everett J. Cheatham — ADDRESS Halena Mo
25. DATE RECD. BY LOCAL REG. Nov. 15-1958
26. REGISTRAR'S SIGNATURE Mrs. J. Elmer Brosseau Per Lena Murray

(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 Everett J. Cheatham

Licensed Embalmer No. 3875

P. O. Address Helena Mo

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.