Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008140
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 381 Primary Registration District No. 4513 Registrar's No. 19

1. PLACE OF DEATH
a. COUNTY Sullivan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Green Castle — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Home — Length of stay in 1b 5 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Sullivan
c. CITY OR TOWN Green Castle — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) No street address — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First: George Middle: Thomas Last: Foster

4. DATE OF DEATH Month Day Year: Feb. 22, 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 3-16-1878
9. AGE (In years last birthday): 80 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Farming
11. BIRTHPLACE (City and state or country): Green Castle, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Thomas Foster
13b. MOTHER'S MAIDEN NAME: Rhoda Willis
14. NAME OF HUSBAND OR WIFE: Byrda Foster

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Clarence Bunch, Address: Milan, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic Nephritis	6 months
DUE TO (c)	Arteriosclerosis	8 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 446X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 Sept 12 1958, to Feb 22, 1959 and last saw ~~her~~ him alive on Feb 21, 1959
Death occurred at 7:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R D Smith (Degree or title) DO.
22b. ADDRESS Green City Mo
22c. DATE SIGNED Feb 24, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Feb. 25, 1959
23c. NAME OF CEMETERY OR CREMATORY: Green Castle Cemetery
23d. LOCATION (City, town, or county) (State): Green Castle, Mo.

24. FUNERAL DIRECTOR: Glenn E. Kent & Son, ADDRESS: Green City, Mo.
25. DATE RECD. BY LOCAL REG.: 3-2-59
26. REGISTRAR'S SIGNATURE: Mrs. M. W. Beckett

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Karl R. Kent

Licensed Embalmer No. 4688

P. O. Address Green City, 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.