

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022886

STATE FILE NUMBER

2 5582

FILED JUN 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

Health
Welfare
Public
Service

300
-56
8 X
03
00

06

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Randolph		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Pocahontas Ark.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cardinal Glen.		Length of stay in 1b 2 Days	d. STREET ADDRESS (If outside, give location) 715 Marr Gen. Del.		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Keith Middle Ray Last Foster			4. DATE OF DEATH Month 6 Day 6 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1958		9. AGE (In years last birthday) 11 Months 23 Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Roy H. Foster			14. MOTHER'S MAIDEN NAME Ical Sutton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Roy Henry Foster-Pocahontas, Ark.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>HYDROCEPHALUS</u>					344-1
DUE TO (c) <u>MALFUNCTION OF VENTRICULOVENOUS SHUNT</u>					3 WEEKS?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					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 _____ 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 ST. LOUIS MO.	
21. I attended the deceased from <u>JUNE 4th 1959</u> to <u>JUNE 6 1959</u> and last saw ^{her} him alive on <u>JUNE 4th</u> . Death occurred at <u>12:45 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert H. Jenkins, M.D.</u>			22b. ADDRESS CARDINAL GLENNON MEMORIAL HOSPITAL 1465 S. GRAND ST LOUIS 4, MO.		22c. DATE SIGNED JUNE 6, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-12-59	23c. NAME OF CEMETERY OR CREMATORY Foster Cemetery		23d. LOCATION (City, town, or county) (State) Randolph County, Ark.
24. FUNERAL DIRECTOR M. C. Mc Nabb		ADDRESS Pocahontas Ark.		25. DATE RECD. BY LOCAL REG. JUN 11 '59	26. REGISTRAR'S SIGNATURE <u>Ward Smith, M.D.</u>

Physician or other person certifying to a death due to natural causes, must be personally examined and must certify to a death due to natural causes. Carer cannot certify to a death due to natural causes. Cause of death must be usually related. Disease in Part I must be usually 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 *[Handwritten Signature]*
Licensed Embalmer No. *34*

P. O. Address

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