

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS OCT 7 1959**

243

Primary Registration District No.

4364

Registrar's No.

32

59-033174

STATE FILE NUMBER

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Newton</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Newton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Stella</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cardwell Memorial Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D 1 Neosho</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>EDWIN</u> Middle <u>CHARLES</u> Last <u>FOSTER</u>			<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-72</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Albro M. Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Maynard</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Hospital Records, Stella Mo.</u>		
<b>18. CAUSE OF DEATH</b> (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) <u>Medullary Paralysis</u>					<u>2 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <u>BASILAR Encephalomalacia</u>
DUE TO (c) <u>ARTERIOSCLEROSIS</u>					<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u>	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 <u>5-31-59</u> to <u>9-17-59</u> and last saw <sup>her</sup> him alive on <u>9-17-59</u> . Death occurred at <u>6:15 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. D.O.</u>			22b. ADDRESS <u>Stella, Mo.</u>		22c. DATE SIGNED <u>9-29-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-21-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>	23d. LOCATION (City, town, or county) (State) <u>Neosho Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Thompson Funeral Home Inc. Neosho Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>9-30-59</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Moherly</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Blyde M. Dameron

Licensed Embalmer No. 5065

P. O. Address Neosho

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.