URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 16 1959

59-036171

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4837

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY
Length of stay in 1b: 2 1/2 DAYS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: LAKESIDE HOSPITAL
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 3607 TROOST AVE
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: JOHN Middle: WILLIAM Last: FOSTER

4. DATE OF DEATH: Month 10 Day 5 Year 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 10-3-59

9. AGE (last birthday): IF UNDER 1 YEAR / IF UNDER 24 HR: Months / Days 2 / Hours 12 / Min. 34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): KANSAS CITY, MISSOURI

12. CITIZEN OF WHAT COUNTRY: AMERICA

13a. FATHER'S NAME: HAROLD SANFORD FOSTER

13b. MOTHER'S MAIDEN NAME: BURNETTA JUNE DELOZIER

14. NAME OF HUSBAND OR WIFE: none

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: Harold S. Foster, Address: 3607 Troost

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): Erythroblastosis fetalis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 10-3-59, to 10-5-59 and last saw her/him alive on 10-5-59
Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: John C. Taylor (Degree or title): D.O.

22b. ADDRESS: 3504 Troost

22c. DATE SIGNED: 10-5-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: OCT. 6. 1959

23c. NAME OF CEMETERY OR CREMATORY: ENGLEWOOD CEM

23d. LOCATION (City, town, or county) (State): CLINTON, MO.

24. FUNERAL DIRECTOR: SICKMAN & DANNING, ADDRESS: CLINTON MO

25. DATE RECD. BY LOCAL REG.: 10-7-59

26. REGISTRAR'S SIGNATURE: Alva Menshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF John S. Taylor

DOCUMENT

ENDED

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Robert L Dunning

Signature of Student Embalmer

Licensed Embalmer No. 4310

P. O. Address Clinton N

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