

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 206

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Length of stay in lb <u>8 months</u>	c. CITY OR TOWN <u>Mount Vernon</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>State Hospital #3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>not given</u> Outside of Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Foster</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 11, 1881</u>	9. AGE (last birthday) <u>88 yrs</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>Davis County, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Henry Foster</u>	13b. MOTHER'S MAIDEN NAME <u>Susan E. Railback</u>	13c. NAME OF HUSBAND OR WIFE <u>unknown</u>
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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>unknown</u>	17. INFORMANT <u>Hospital records</u> Address <u></u>
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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) <u>Arteriosclerosis Heart Disease</u>		
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>Gen. Arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Dysphoria</u>		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.) <u></u>
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> p.m. <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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>April 10, 1959</u> to <u>Dec 16, 1959</u> and last saw him alive on <u>Dec 16, 1959</u>	
Death occurred at <u>4:40 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>W.C. Bradley</u> (Degree or title)	22b. ADDRESS <u>State Hospital #3 Nevada, Mo</u>	22c. DATE SIGNED <u>12/16/59</u>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/14/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orange Cem</u>	23d. LOCATION (City, town, or county) <u>Mt. Vernon</u> (State) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>Max Fossett</u> ADDRESS <u>Mt. Vernon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-28-1959</u>	26. REGISTRAR'S SIGNATURE <u>Arma J. Ferry</u>
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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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Lloyd C. McCard*

Licensed Embalmer No. 4853

P. O. Address Florida, 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.