RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS FEB 18 1960

2 1404 60-008215

STATE FILE NUMBER

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

DED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. John's Hospital
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 4403 Athlone Ave.
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: Thurman; Middle:; Last: Foster
4. DATE OF DEATH: Month: Feb.; Day: 5th.; Year: 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 9-29-1887
9. AGE (last birthday): 72
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HR: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: U.K.
11. BIRTHPLACE (City and state or country): U.K.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: U.K.
13b. MOTHER'S MAIDEN NAME: U.K.
14. NAME OF HUSBAND OR WIFE: U.K.
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.: U.K.
17. INFORMANT: Mrs. Cormelia Phillips, Address: Van Gore, Main

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): Chronic Interstitial Nephritis
Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH: 7yrs 6 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): 420.0
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Bronchopneumonia – Terminal
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 12-24-59 to Feb 5-60 and last saw her/him alive on Feb 4-'60
Death occurred at 2:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Upshaw McMahon, M.D. (Degree or title)
22b. ADDRESS: 634 N. Grand Blvd
22c. DATE SIGNED: 2-5-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-9-1960
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's White Chapel Cemetery
23d. LOCATION (City, town, or county) (State): Kilmarnack, Virginia

24. FUNERAL DIRECTOR: Arthur J. Donnelly
ADDRESS: 3840 Lindell Blvd.
25. DATE RECD. BY LOCAL REG.: FEB 6 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

H.T.

DOCUMENT

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 469

P. O. Address 384 Lin

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