

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-022366
STATE FILE NUMBER

FILED VS JUN 20 1960 042

1000

660

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph, Missouri		Length of stay in 1b 2 days	c. CITY OR TOWN St. Joseph, Missouri Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 723 South 11th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Keyth Foster			4. DATE OF DEATH Month June Day 11 Year 1960		
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 Nov. 27, 1923	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY Interior Decorator	11. BIRTHPLACE (City and state or country) Reger, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Mr. Clyde F. Foster		13b. MOTHER'S MAIDEN NAME Eva K. King		14. NAME OF HUSBAND OR WIFE Single	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mr. Clyde F. Foster, 723 S 11th St.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Asthmaticus		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Broncheal Asthma intervals approx 4 yr. DUE TO (c) _____		
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 _____ a.m. _____ p.m. Month, Day, Year _____	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 **11-18-58** to **6-11-60** and last saw ^{free}him alive on **6-11-60**
Death occurred at **11:55 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wm. B. Rost, M.D. (Degree or title)		22b. ADDRESS 316 North St. Joseph Mo		22c. DATE SIGNED 6-12-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 14, 1960	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Missouri	
24. FUNERAL DIRECTOR Heaton-Bowman F.H.		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. June 13, 1960	26. REGISTRAR'S SIGNATURE Mr. Clark Woodell

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 William Spalding

Licensed Embalmer No. 4535

P. O. Address St. Joseph

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.