URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-028312

FILED VS JUL 22 1960 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7004 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri.
Length of stay in 1b: 10 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Chronic Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri. b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 5312 Wells
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Ellen Last: Foust
4. DATE OF DEATH: Month 7 Day 11 Year 60
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 8/7/1880
9. AGE (last birthday): 79
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): West Plains, Missouri.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: George Hensley
13b. MOTHER'S MAIDEN NAME: Sally McGinness
14. NAME OF HUSBAND OR WIFE: Aleck Foust
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): Nil
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Nellie Crum, 5312 Wells Avenue.

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 days.
420.0
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) Generalized Arteriosclerosis — 10 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Multiple Decubitus Ulcers - 10 days.
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

BY AFFIDAVIT OF

21. I attended the deceased from 6-30-60, to 7-11-60 and last saw her/him alive on 7-11-60
Death occurred at 7:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): John W. Beckham, M.D.
22b. ADDRESS: 5800 Arsenal
22c. DATE SIGNED: 7/12/60
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7/11/60
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Corning, Arkansas.
24. FUNERAL DIRECTOR: Albert H. Hoppe, Inc., ADDRESS: 4700 Washington Blvd.,
25. DATE RECD. BY LOCAL REG.: JUL 12 1960
26. REGISTRAR'S SIGNATURE: Hoad Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 J Wm Denkler

Licensed Embalmer No. 365-3

P. O. Address St Lou

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.