

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043179

LED VS DEC 8 1960 394

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 80

1. PLACE OF DEATH a. COUNTY Reynolds		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jackson typ		Length of stay in 1b 4 yrs	c. CITY OR TOWN Bunker Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson Typ Fork		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) XX Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Lester Middle _____ Last Foster			4. DATE OF DEATH Month Nov Day 23 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-15-28	9. AGE (last birthday) 32	IF UNDER 1 YEAR Months 0 Days 8	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY Steel Mill work	11. BIRTHPLACE (City and state or country) Shannon Co Mo	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME Wilburn Foster	13b. MOTHER'S MAIDEN NAME Dema Black	14. NAME OF HUSBAND OR WIFE Dessie Smith
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. 36 0084 492 28	17. INFORMANT Mrs Leslie Smith Foster Bunker Mo Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fracture of skull		INTERVAL BETWEEN ONSET AND DEATH minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) falling of tree , fracture of skull
20c. TIME OF INJURY Hour _____ a.m. _____ 3.00 P.M.	Month, Day, Year 11-23-60	

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.) Federal Forest	20f. CITY, TOWN, OR LOCATION 5 mi. West of Centerville	COUNTY Reynolds County Mo.	STATE
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 3 P _____ m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>W.D. Hoelger</i> Coroner		22b. ADDRESS Lesterville Missouri		22c. DATE SIGNED 11-26-60
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 11-26-60	23c. NAME OF CEMETERY OR CREMATORY Upper Bee Fork Cem	23d. LOCATION (City, town, or county) (State) Reynolds Co Mo	
24. FUNERAL DIRECTOR Shencer Funeral Home Inc ADDRESS _____		25. DATE RECD. BY LOCAL REG. Dec 1-1960	26. REGISTRAR'S SIGNATURE <i>Ema Jarwid</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1960

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APR 4

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Carl H. Payne

Licensed Embalmer No. 23

P. O. Address Wichita

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