

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048329

FILED VS DEC 16 1960

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3507 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Koch</u>		Length of stay in 1b <u>12 days</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rob't. Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4010 West Bell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Huston</u> Last <u>Foster</u>			4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-09</u>	9. AGE (last birthday) <u>50</u>	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)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Alabama</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Davis Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Harris</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Foster</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>493-20-4559</u>		17. INFORMANT <u>WOODROW</u> Address <u>KOCHER</u> <u>Robert Koch Hospital, Koch, Mo.</u>	

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>Myocardial infarction</u>			
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			
DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>			
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 <u>11-18-60</u> to <u>11-30-60</u> and last saw her/him alive on <u>11-29-60</u> Death occurred at <u>6:45</u> <u>A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Asst R. Brown M.D.</u>		22b. ADDRESS <u>Rob't. Koch Hosp., Koch, Mo.</u>		22c. DATE SIGNED <u>11-30-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/5/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Thomas Jackson</u>		25. DATE RECD. BY LOCAL REG. <u>12-2-60</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>	

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 Leroy U. Dennis

Licensed Embalmer No. 4523

P. O. Address 4251 WA

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.