

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029772

STATE FILE NUMBER

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 22

AMENDED

FILED SEP 6 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp.</u>		Length of stay in 1b <u>00000</u>	c. CITY OR TOWN <u>Mt. Pleasant Twp.</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>140th &amp; Raytown Rd.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Richards-Gebaur AFB</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>O.</u> Last <u>Foster</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 8, 1929</u>	9. AGE (last birthday) <u>32</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Air Force</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Armed Services.</u>	11. BIRTHPLACE (City and state or country) <u>Carlo, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Floyd Foster</u>	13b. MOTHER'S MAIDEN NAME <u>Lucy Harris</u>	14. NAME OF HUSBAND OR WIFE <u>Gwendolyn Foster</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Gwendolyn Foster, Ft. Worth, Texas</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO (b) <u>numerous lacerations</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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 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.) <u>One car left road + struck</u>
20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>8-29-61</u> a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>

20f. CITY, TOWN, OR LOCATION <u>Jackson</u>	COUNTY <u>MO</u>	STATE <u>MO</u>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Hugh A Owens Coronor</u>	22b. ADDRESS <u>152 Main Station</u>	22c. DATE SIGNED <u>8-30-61</u>
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug. 31, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carlo, Illinois</u>

24. FUNERAL DIRECTOR <u>Langsford Funeral Home</u> <u>Lee's Summit, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>8-31-61</u>	26. REGISTRAR'S SIGNATURE <u>Herb Dodds</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

SEP 11 1961

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *D. B. Lingsford Jr.*  
Licensed Embalmer No. *4962*  
P. O. Address *Leis Summit*

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.