

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040821

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 133

Primary Registration District No. 3022

Registrar's No. 153

STATE FILE NUMBER

AMENDED

FILED DEC 11 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>									
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Length of stay in 1b <u>12 yr</u>		c. CITY OR TOWN <u>Bethany</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>at home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <u>105 S 20th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Green Foster</u>				4. DATE OF DEATH Month Day Year <u>12-1-1961</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-10-1862</u>		9. AGE (last birthday) <u>99</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>21</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>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state or country) <u>Sherman, Texas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>					
13a. FATHER'S NAME <u>Thomas Foster</u>				13b. MOTHER'S MAIDEN NAME <u>Catherine Jane Smith</u>				14. NAME OF HUSBAND OR WIFE <u>Mattie</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Jay Thomas</u>		Address <u>Bethany, Mo.</u>					
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>CORONARY THROMBOSIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>HYPERTENSIVE HEART DISEASE</u>							20 YEARS			
			DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							20 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</u>								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.) <u>---</u>					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year <u>---</u>		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.) <u>---</u>		20f. CITY, TOWN, OR LOCATION <u>---</u>		COUNTY <u>---</u>		STATE <u>---</u>	
21. I attended the deceased from <u>10/14/55</u> to <u>12/1/61</u> and last saw him alive on <u>11/29/61</u> Death occurred at <u>1:15</u> P.m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D. O.</u>						22b. ADDRESS <u>Bethany, Mo.</u>			22c. DATE SIGNED <u>12-2-61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-2-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Miriam</u>				23d. LOCATION (City, town, or county) (State) <u>Bethany, Mo.</u>					
24. FUNERAL DIRECTOR <u>[Signature]</u> <u>Bethany, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>12-2-1961</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

JUN 26 1962

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 M. B. Haas
M. B. Haas
Licensed Embalmer No. 3899

P. O. Address Bethany, Mo.

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.