

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

6558-61-044687
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri Kansas b. COUNTY Jackson Wyandotte	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 29 5 weeks	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 900 North 8th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HOMER Middle FRANKLIN Last FOUST NEE FAUST			4. DATE OF DEATH Month December Day 26 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-17-97	9. AGE (last birthday) 64	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) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail Sales		11. BIRTHPLACE (City and state or country) Lone Jack, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Frank Foust			13b. MOTHER'S MAIDEN NAME Ella Mary L. White			14. NAME OF HUSBAND OR WIFE None	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		17. INFORMANT Harry R. Foust, 8348 Lowell, Overland Park, Kas.	
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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:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Carcinoma of left lung with metastases			
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

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
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21 VA attended the deceased from **November 22, 1961** to **December 26, 1961** last saw her/him alive on _____
Death occurred at **4:50 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M. D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 12-26-61
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) Cremated 12-28-61	23c. NAME OF CEMETERY OR CREMATORY D.W. NEWCOMER'S CREMATORY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.
24. FUNERAL DIRECTOR ADDRESS D.W. Newcomer's Sons 15. E.H.	25. DATE RECD. BY LOCAL REG. 12-29-61	26. REGISTRAR'S SIGNATURE [Signature]

DATE AMENDED: 1/3/62
 INSTEAD OF: 29 yrs., Missouri, Jackson
 SHOULD READ: 5 weeks, Kansas, Wyandotte
 ITEM NO. 1b, 2a, b; 13b; 17
 BY AFFIDAVIT OF INFORMANT: Mary L. White; Ella L. White; Harry R. Foust, Overland Park, Kas.

MEDICAL CERTIFICATION

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

Robert E. Larson

Licensed Embalmer No. 4849

P. O. Address J. C. Ward

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.