

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-022006
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 712

FILED JUN 25 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF S. MELUNY, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 32 years	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Meth. Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1704 Highly Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CLYDE F. FOSTER			4. DATE OF DEATH Month June Day 13 Year 1962
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 7/14/1899
9. AGE (last birthday) 62		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) Attendant		10b. KIND OF BUSINESS OR INDUSTRY State Hospital	11. BIRTHPLACE (City and state or country) Milan, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME James Foster	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Eva K. Foster	
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. unknown	17. INFORMANT Mrs. Eva K. Foster, 1704 Highly, St. Joseph, 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) Myocardial failure DUE TO (b) Preexisting Valvular Heart Disease. DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH At once
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given above Was passing car, when he turned across his lane		PART III. If deceased was female was perished by _____ days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Striking telephone pole on right side of highway.			
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.) See part 2.	
20c. TIME OF INJURY Hour 10:2 a.m. _____ p.m. _____	Month, Day, Year June 13 62.	Highway 36 -3500 Block	
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.) Saint Joseph	20f. CITY, TOWN, OR LOCATION Buchanan	COUNTY Ma STATE
21. I attended the deceased body _____ to _____ and last saw him _____ on June 13th 1962 Death occurred at 10:02 p.m. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) S.E. Meluney M.D. Coronor		22b. ADDRESS 214 Kirkpatrick Bldg Saint Joseph 8, Mo.	22c. DATE SIGNED 6 1962
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6/16/1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR Norton-Bowman		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. June 20, 1962
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell			

USE BLACK INK OR TYPEWRITER RIBBON

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

Theron O. Smith

Licensed Embalmer No.

3928

P. O. Address

St Joseph Md

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.