

WAILE FLAINLI—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

State File No. _____

Registration District No. 347

Primary Registration District No. 3018

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Henry 1
 (b) City or town Clinton
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Clinton General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 hrs
 (Specify whether
 In this community 17 yrs
 years, months or days)

3. (a) PRINT FULL NAME OLLIE WILSON FOSTER

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dora Foster 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 4 - 27 - 1884
 (Month) (Day) (Year)

Years	Months	Days	If less than one day
<u>55</u>	<u>7</u>	<u>28</u>	hr. _____ min.

9. Birthplace Advance N.C.
 (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Elect. R.R. before

12. Name Samuel Foster 1

13. Birthplace Advance North Carolina
 (City, town, or county) (State or foreign country)

14. Maiden name Catherine Allen 1

15. Birthplace Advance N.C.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dora Foster
 (b) Address Clinton Mo RFD

17. (a) burial (b) Date thereof 12-20-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cem

18. (a) Signature of funeral director Thos. Wilkerson
 (b) Address Clinton Mo

19. (a) 12-30-39 (b) W. J. R. Naughton
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
 (c) City or town Clinton - "Rural"
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18
 year 1939 hour 6 minute 15 A. M.

21. I hereby certify that I attended the deceased from 34 to Dec 18 1939
 that I last saw her alive on Dec 18 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Heart 12/18/39

Due to _____
 Due to 80

Other conditions Tuber dorsalis unknown
 (Include pregnancy within 3 months of death)

Major findings: Of operations none
 Of autopsy none

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 Means of injury _____

28. Signature S B Hughes (M. D. or _____)
 Address Clinton Mo. Date signed 12/20/39

OCT 31 1949

RECEIVED

District Health Officer No. 7,

District number 1-40-68

Date filed 1-9-40

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 _____

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Fred Wilkinson

Licensed Embalmer No. 2478

P. O. Address Clinton M

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 this body is not embalmed, above space should be left blank.