

FILED DEC 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36830

State File No.

BIRTH NO.		REG. DIST. NO. <u>137</u>		PRIMARY REG. DIST. NO. <u>3023</u>		Registrar's No. <u>23</u>	
1. PLACE OF DEATH a. COUNTY <u>HENRY</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>HENRY</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLINTON</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLINTON</u> <u>0422</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>MOORES NURSING HOME</u>				d. STREET ADDRESS (If rural, give location) <u>901 N. SECOND ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ELBERT</u> b. (Middle) <u>L.</u> c. (Last) <u>FOSTER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 25, 1950</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>Sept. 26, 1888</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u>	IF UNDER 14 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>		11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>George Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Emma P. Garratt</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Eloise Foster, Clinton Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Embolism</u> ANTECEDENT CAUSES <u>Valvular Endocarditis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Valvular Endocarditis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>332X</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Nov 7</u> to <u>11/25, 1950</u> , that I last saw the deceased alive on <u>11/24/1950</u> , and that death occurred at <u>6 A.M.</u> ; from the causes and on the date stated above.							
23a. SIGNATURE <u>Ed. E. Peeler MD</u> (Degree or title)				23b. ADDRESS <u>Clinton Mo</u>		23c. DATE SIGNED <u>11/25/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 27 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Park Chapel</u>		24d. LOCATION (City, town, or county) (State) <u>Henry Co. Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Nov-25-50</u>		REGISTRAR'S SIGNATURE <u>Florence Adaire</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Fred E. ...</u>		ADDRESS <u>Clinton Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 12-4-57
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 12-4-57

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 _____
Student Embalmer

Signed _____

Robert L. Dunning

Licensed Embalmer No. *CH 710*

P. O. Address *Clinton, 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 this body is not embalmed, fact should be so stated above.