19 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33588

Registration District No. 784 | Primary Registration District No. 200 | Registrar's No. 1664

1. PLACE OF DEATH: 3

(a) County: Saint Louis

(b) City or town: Jefferson Barracks (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Vet. Adm. Fac., Jefferson Bks., Mo. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm: 8-10-39 (Specify whether years, months or days)

In this community: Unknown

2. USUAL RESIDENCE OF DECEASED: 2

(a) State: Illinois (b) County: --

(c) City or town: Sparta (If outside city or town limits, write "RURAL")

(d) Street No.: 207 West Main Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? -- years.

3. (a) PRINT FULL NAME: Morrison R. FOSTER 236

3. (b) If veteran, name war: World

3. (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: Anna C.

6. (c) Age of husband or wife if alive: -- years

7. Birth date of deceased: July 5, 1890 (Month) (Day) (Year)

8. AGE: Years 49 | Months 2 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace: Cairo (City, town, or county) Illinois (State or foreign country)

10. Usual occupation: Postal Clerk

11. Industry or business: --

FATHER

12. Name: John Scott Foster

13. Birthplace: Sparta, Illinois (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Margaret Watson

15. Birthplace: Sparta, Illinois (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Minnie Foster

(b) Address: VAF., Jefferson Barracks, Mo.

17. (a) removal (Burial, cremation, or removal) (b) Date thereof: 9-21-39 (Month) (Day) (Year)

(c) Place: burial or cremation: Sparta, Ill.

18. (a) Signature of funeral director: Albert H. Hoppe Inc.

(b) Address: 4700 Washington Blvd.

19. (a) SEP 19 1939 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19 year 1939 hour 8 minute 05 A. M.

21. I hereby certify that I attended the deceased from August 10, 1939, to September 19, 1939 that I last saw him alive on September 19, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Biliary cirrhosis, chronic, severe; cause undetermined	July, 1939
Due to:	
Due to:	
Other conditions: None (Include pregnancy within 3 months of death)	
Major findings: Of operations: Biliary cirrhosis	
Of autopsy: See cause of death	

24 hr

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)

(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? (Specify type of place)

While at work (e) Means of injury

23. Signature: C.W. HUGHES, M.D., Chief Med. Officer (M. D. or other)

Address: VAF., Jefferson Bks., Mo. Date signed: 9-19-39

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Albert G. Hoppe

Licensed Embalmer No. 2971

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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