

Registration District No. **399**Primary Registration District No. **1002**Registrar's No. **4645**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Lakeside Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 Days**
 (Specify whether
 In this community **18 years**
 years, months or days)

3. (a) PRINT FULL NAME **Mrs. Emma L. Foster 236**3. (b) If veteran, name war **- No** 3. (c) Social Security No. **No -**4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**6. (b) Name of husband or wife **A. B. Foster** 6. (c) Age of husband or wife if alive **69** years7. Birth date of deceased **August 20, 1867**
(Month) (Day) (Year)8. AGE: Years **72** Months **3** Days **16** If less than one day hr. min.9. Birthplace **Chicago, Illinois**
(City, town, or county) (State or foreign country)10. Usual occupation **At home**

11. Industry or business

12. Name **Peter Schlund**13. Birthplace **Germany**
(City, town, or county) (State or foreign country)14. Maiden name **Don't Know**15. Birthplace **Don't Know**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **AB Foster**(b) Address **3215 Chestnut**17. (a) **Burial** (b) Date thereof **Dec. 8, 1939**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Mt. Moriah**18. (a) Signature of funeral director **Freeman Mortuary**(b) Address **104 W. 42nd St., K.C., Mo.**19. (a) **Dec. 7, 1939** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **3215 Chestnut**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **6**
year **1939** hour _____ minute **1:30 A.M.**21. I hereby certify that I attended the deceased from **Dec. 4**
1939, to **Dec. 6**, **1939**,
that I last saw him alive on **Dec. 6**, **1939**,
and that death occurred on the date and hour stated above.Immediate cause of death **Exhaustive Toxic Myocarditis** Duration **?**Due to **Gangrene Appendicitis** **?**Due to **Paralytic Ileus Peritonitis** **?**Other conditions **121**
(Include pregnancy within 3 months of death)Major findings: **Of operations** PHYSICIAN _____Of autopsy **Evidence of Paralytic Ileus. Acute Dil. Stomach. Ruptured Sigmoid Appendix.** 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 _____

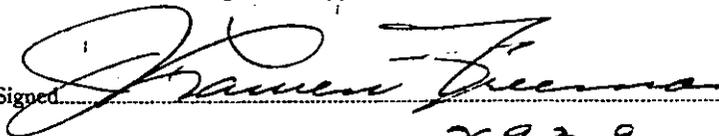
(c) Where did injury occur? _____
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place? **3**While at work? _____
(Specify type of place) (e) Means of injury _____23. Signature **H. T. Wittenberger** (M.D. or other) **D.**Address **214 Bought Bedg** Date signed **12/6/39**

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.....



Licensed Embalmer No. 2939

P. O. Address K. O. 240

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.