LED APR 23 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12072

Do not use this space.

1. PLACE OF DEATH
(a) County Platte
(b) Township Green
or
(c) City 0
Registration District No. 692
Primary Registration District No. 59193
Registered No.
(d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME George Frank Foster
(a) Residence, No. One and one half Miles East of Dearborn St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Laura Foster
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 27th 1868
7. AGE: YEARS 71 | MONTHS 9 | DAYS 3 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farming
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
10. Date deceased last worked at this occupation (month and year) Jan 1 1935
11. Total time (years) spent in this occupation 45

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buchanan Missouri 0

FATHER
13. NAME George Philson Foster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Roanoke co. Virginia 1

MOTHER
15. MAIDEN NAME Armilda Hainline
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buchanan co. Missouri 1

17. INFORMANT (ADDRESS) Laura Foster Dearborn Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Dearborn Mo Cem. DATE Mch 31st 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lucian Davis Dearborn Mo.
20. FILED March 31, 1940 M H Moore Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mch 30 - 1940
22. I HEREBY CERTIFY, That I attended deceased from July 4th, 1935, to March 30, 1940
Last saw him alive on March 28th, 1940 Death is said to have occurred on the date stated above, at 9 a. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemiplegia	7-4-35

Other contributory causes of importance: None given

Name of operation None Date of
What test confirmed diagnosis? Phy Ex Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury No, 19
Where did injury occur? None
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. None
Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify No
(Signed) S. L. Durham, M. D.
(Address) Dearborn Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

RECEIVED
District Health Officer No. 11,
District File Number 440-546
Date Filed APR 13 1940

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 W. B. Benson

Licensed Embalmer No. 3148

P. O. Address Dearborn Mo

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

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

o. 2B
-21-40
X22859

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12072

Registration District No. 692 Primary Registration District No. 3919 B Registrar's No.

1. PLACE OF DEATH
(a) County Platte
(b) City or town Green Ivo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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.

3. (a) PRINT FULL NAME Geo Frank Foster
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced wd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 71 Months 9 Days 3 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemiplegia	
Due to Cerebral Hemorrhage	4½ years
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 S. L. Durham (M. D. or other)
Address Denham Mo Date signed

SUPPLEMENTARY

1940
S-12072