

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 MAY 15 1940

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Wesley Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 Yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Mary Louise 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 Single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Sept. 23rd. 1935
(Month) (Day) (Year)

8. AGE: Years 4 Months 6 Days 20 If less than one day hr. _____ min. _____

9. Birthplace Kansas City, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Child at home

11. Industry or business _____

MOTHER FATHER { 12. Name Walter Foster
 13. Birthplace Kansas
(City, town, or county) (State or foreign country)
 14. Maiden name Catherine Jenkins
 15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Walter Foster

(b) Address 1010 Prospect

17. (a) Burial (b) Date thereof 4/16/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director H. F. Mayberry

(b) Address 2315 Linwood Blvd.

19. (a) April 15, 1940 (b) _____
(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. 1010 Prospect
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th.
 year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from April 12, 1940 to April 12, 1940

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death

Thyroid death Duration 4 hours

Due to 67

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy An enlarged thyroid

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 no
 (c) Where did injury occur? no
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? no

While at work? no (Specify type of place) (e) Means of injury no

23. Signature J. F. Mackay (M. D. or other)
 Address Professional Bldg Date signed 4-13-40

*Dr. J. H. Manning
Pres. M. B. C. S.*

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 *R. E. Manning*

Licensed Embalmer No. 2560

P. O. Address 2315 Linwood Blvd.

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.