

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24399**  
Registrar's No. **3009**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City, Missouri**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **3619 Virginia**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **4 1/2 Years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limit write "RURAL")  
(d) Street No. **3619 Virginia**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **28TH**  
year **1940** hour **10** minute **40 P.M.**  
21. I hereby certify that I attended the deceased from **MAY 15**  
**1940** to **JULY 28**, 19**40**  
that I last saw him alive on **JULY 28**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **ARTIC ANEURYSM**  
**ECLEROSIS**

Due to **STRAIN**  
Due to **SYPHILIS**

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Duration  
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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury **3**

23. Signature **M. M. Craue** (M. D. or other) **20**  
Address **505 SHUREKT** Date signed **7-28-40**

3. (a) PRINT FULL NAME **Edward A Foos** **200**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Edna Foos** 6. (c) Age of husband or wife if alive **Unknown**

7. Birth date of deceased: (Month) **2/** (Day) **21** (Year) **1876**

8. AGE: Years **64** Months **5** Days **7** If less than one day hr. min.

9. Birthplace **Fremont Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Oil Driller**

11. Industry or business

MOTHER FATHER  
12. Name **John Foos**  
13. Birthplace **Unknown New York**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Eva Buchman**  
15. Birthplace **Unknown New York**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Edna Middaught**  
(b) Address **3619 Virginia**

17. (a) **3619 Virginia** (b) Date thereof **7/29/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Green Springs, Ohio**

18. (a) Signature of funeral director **Melody-McGillley**  
(b) Address **3155 Euclid Uneral Home**

19. (a) **July 29, 1940** (b) **M-M Craue**  
(Date received local registrar) (Registrar's signature)

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

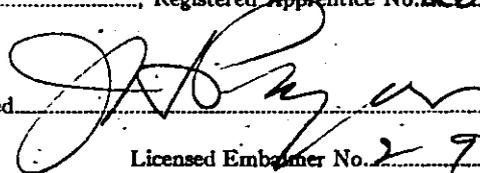
**STATEMENT BY LICENSED EMBALMER**

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. 267

working under my personal supervision.

Signed



Licensed Embalmer No. 2989

P. O. Address KC 70

**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.**