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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35115**

NOV 15 1940

Registration District No. **213**

Primary Registration District No. **3014**

Registrar's No. **266**

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day.
(Specify whether
In this community 17 years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
(c) City or town Jefferson City,
(If outside city or town limits, write "RURAL")
(d) Street No. 713 Ewing Drive
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18th
year 1940 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from Oct 15
1940 to Oct 18 1940
that I last saw h. alive on Oct 18
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral
hemorrhage

Due to Hypertension

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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 _____

23. Signature Dean A. Taylor (M. D. or other) M.D.
Address Jefferson City Date signed 10-18-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Mrs. Dora Foster

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James W. Foster 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Feb. 9, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
54 8 9 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Robert Kelly

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Florence McMillian

15. Birthplace U. S. A.
(City, town, or county) (State or foreign country)

16. (a) Informant James W. Foster

(b) Address 713 Ewing Dr. J. C. Mo.

17. (a) removal (b) Date thereof Oct. 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pittsburg, Kansas

18. (a) Signature of funeral director John F. Hainich

(b) Address Jefferson City, Mo.

19. (a) 10-19-40 (b) D. W. Beardsley M.D.
(Date received local registrar) (Registrar's signature)

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

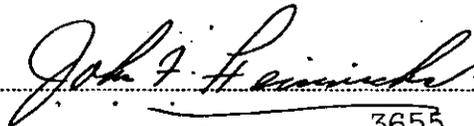
STATEMENT BY LICENSED EMBALMER

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.....

working under my personal supervision..

Signed.....



Licensed Embalmer No. 3655

P. O. Address... Jefferson City, Mo.

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, fact should be so stated above.