No. 2
4-13-40
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41262 4655

FILED JAN 8 1941

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

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

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: Vinyard Park Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community 35 Years

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. 718 Troost
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ... years.

3. (a) PRINT FULL NAME Mildred Foster
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Fe
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Layton Foster
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased May 13 1903 (Month) (Day) (Year)

8. AGE: Years 37 Months 6 Days 22 If less than one day ... hr. ... min.

9. Birthplace Independence Mo (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business 9
MOTHER FATHER
12. Name No Record
13. Birthplace No Record 9 (City, town, or county) (State or foreign country)
14. Maiden name No Record
15. Birthplace No Record (City, town, or county) (State or foreign country)
16. (a) Informant Layton A. Foster
(b) Address 718 Troost
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hill
18. (a) Signature of funeral director Mrs C R Foster
(b) Address 918 Brooklyn K.C. Mo
19. (a) 12-7-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 5 year 1940 hour 8 minute 45 P. M.
21. I hereby certify that I attended the deceased from Dec 1, 1940, to Dec 5 1940 that I last saw him alive on Dec 5, 1940 and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Coronary Thrombosis
Due to endocarditis Coronary
Due to 39.4
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations Left Corneal cyst Hydro Keratitis (Non-Malig)
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 H H Young (M. D. or other)
Address 416 Chambers Bldg Date signed 12/5/40

(Licensed Embalmer's Statement on Reverse Side)

Chambers Bg.
Ha. 0231

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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 Me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed E. H. Wise

Licensed Embalmer No. 2520

P. O. Address K. C. 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.