No. 2
4-41
7-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 20 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6317

Registration District No. 143 Primary Registration District No. 4116 Registrar's No. 73

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

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Clark 23
(c) City or town Wayland 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 1 (~~Yes~~ or No)
If yes, name country

3. (a) PRINT FULL NAME Charles Lee Foster.
3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Child 0
6. (b) Name of husband or wife Child
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 17, (Day) 1941 (Year)

8. AGE: Years 0 Months 7 Days 25 If less than one day hr. min.

9. Birthplace Kahoka, Missouri 0
(City, town, or county) (State or foreign country)
10. Usual occupation Child
11. Industry or business —

FATHER
12. Name Charles E. Foster 0
13. Birthplace Kansas City, Missouri
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mildred Myrtle
15. Birthplace California, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Charles E. Foster.
(b) Address Wayland, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Sand Cemetery
18. (a) Signature of funeral director N. F. Kicker
(b) Address Wayland, Mo.
19. (a) Feb. 18, 1942 (Date received local registrar) (b) Lula Fern Carver (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12th year 1942 hour 9 minute 30 P. M.
21. I hereby certify that I attended the deceased from February 12th, 1942 to 19
that I last saw him alive on February 12th 10 A.M. 1942
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Broncho-pneumonia
Due to
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 2
23. Signature Grace L. Gray (~~M. D. or other~~) D. O.
Address Kahoka, Missouri Date signed 2-14-42

1681

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-42-565
Date Filed MAR 18 1942

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 Temporary Preservation, Registered Apprentice No. working under my personal supervision.

Signed H. F. Rucker

Licensed Embalmer No. 2611

P. O. Address Wayland

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

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
X29288

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. 6317

Registration District No. 193 Primary Registration District No. 4116 Registrar's No.

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Wayland
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Charles L. 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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 17 (Day) 1904 (Year)
8. AGE: Years — Months 7 Days 29 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 day year hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 107	
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 Grace L. Gray (M. D. or other) MD
Address Kahoka, Mo. Date signed 4-6-42

SUPPLEMENTARY