No. 2
—1-4-41
5-17-39
PI X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 27 1942

Registration District No. 7[illegible]

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15698

Primary Registration District No. 20

Registrar's No. 881

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 days. (Specify whether years, months or days)
In this community Since April 6, 1942

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Hardin 11

(c) City or town Elizabethtown 0
(If outside city or town limits, write "RURAL")

(d) Street No. None 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No).
If yes, name country

3. (a) PRINT FULL NAME FOSTER, Lee A.

3. (b) If veteran, name war World War (1918). 3. (c) Social Security No. Not Available

4. Sex Male (1) 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fadie Foster 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased July (Month) 4 (Day) 1888 (Year)

8. AGE: Years	Months	Days	If less than one day
53	9	15	hr. min.

9. Birthplace Rock Creek (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Horace Foster
13. Birthplace (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Julie Frailey
15. Birthplace (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Government Records
(b) Address Vet. Adm. Fac., Jeff. Bks., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/21/42 (Month) (Day) (Year)
(c) Place: burial or cremation Roseclair Ill.

18. (a) Signature of funeral director Albert H Hoppe
(b) Address 4700 Washington

19. (a) APR 20 1942 (Date received local registrar) (b) C. G. McGarvey M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19 year 1942 hour 6 minute 20 A. M.

21. I hereby certify that I attended the deceased from 4/6/42, 19..., to 4/19/42, 19...; that I last saw him alive on 4/19/42, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary arteriosclerotic heart disease, myocardial damage, auricular fibrildation and myocardial insufficiency. Duration---- Unknown — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy No autopsy done

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 L. M. COCHRAN, M.D., (M. D. or other)
Address Chief Medical Officer. Date signed 4/19/42
per [illegible]

707

(Licensed Embalmer's Statement on Reverse Side)

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 J. G. Sullivan

Licensed Embalmer No. 1121

P. O. Address.....

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 15698
Registrar's No. 887

State of MO

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Jefferson Barracks (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Veterans admin Facility (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)
In this community Since April 6 1942

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill (b) County Hardin
(c) City or town Elizabethtown (If outside city or town limits, write RURAL)
(d) Street No. — (If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) FULL NAME Lee A. Foster
3. (b) If veteran, name war World War 1918
3. (c) Social Security No. —
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Cadie
6. (c) Age of husband or wife if alive Living years
7. Birth date of deceased July (Month) 4 (Day) 1888 (Year)
8. AGE: Years 53 Months 9 Days 15 If less than one day hr. min.
9. Birthplace Rock Creek (City, town, or county) Ill (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) Ill (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) Ill (State or foreign country)
16. (a) Informant's own signature
(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 April day 1 year 1942 hour 6 minute 20 AM
21. I hereby certify that I attended the deceased from 4-6, 1942 to 4-19, 1942 that I last saw him alive on 4-19, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary arteriosclerotic heart disease, myocardial
Due to damage auricular fibrillation and myocardial
Due to insufficiency
Duration Unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN 944

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 (M.D. or other)
Address Date signed

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493