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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 9 1942

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

32712

State File No.

Registration District No. 49

Primary Registration District No. 1002

Registrar's No. 4012

**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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 Mo. & 1 day (Specify whether years, months or days)

In this community: 34 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.: 3512 Locust
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: 0

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3. (a) PRINT FULL NAME: Mrs. Olive F. Foster

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Samuel S. Foster

6. (c) Age of husband or wife if alive: -- years

7. Birth date of deceased: May (Month) 14 (Day) 1853 (Year)

8. AGE: Years 89 | Months 5 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Jackson Co. (City, town, or county) Iowa (State or foreign country)

10. Usual occupation: At Home

11. Industry or business:

MOTHER FATHER

12. Name: John Hodges

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

MOTHER

14. Maiden name: Unknown

15. Birthplace: (City, town, or county) Pennsylvania (State or foreign country)

16. (a) Informant: G. H. Foster

(b) Address: 3512 Locust

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-31-1942 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Moriah Cemetery

18. (a) Signature of funeral director: Freeman Mortuary

(b) Address: Kansas City, Missouri

19. (a) 10-30-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month: Oct. day: 29th year: 1942 hour: 12 minute: 10 A.M.

21. I hereby certify that I attended the deceased from 9-28-42, 19__, to 10-29-42, 19__; that I last saw her alive on 10-29-42, 19__; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Carcinoma of the cervix; | |
| Lobar pneumonia | |
| Due to: 48 a | |
| Due to: | |
| Other conditions (Include pregnancy within 3 months of death): | |
| Major findings: Of operations: | |
| Of autopsy: See above | |

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: Drucy R. Thom (M. D. or other)

Address: Med. Dir. K.C. General Hospital Date signed

(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 Clarence W Chels

Licensed Embalmer No. 3473

P. O. Address Kc 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.**