

Registration District No. **149**

Primary Registration District No. **1002**

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:
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 **7 days**
(Specify whether)
 In this community **43 yrs**
years, months or days

3. (a) PRINT FULL NAME **Alva Foster**
 3. (b) If veteran, name war **no**
 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife **Virginia Foster**
 6. (c) Age of husband or wife if alive **years**
 7. Birth date of deceased **Sept-29-1875**
(Month) (Day) (Year)

8. AGE: Years **67** Months **6** Days **12**
If less than one day hr. min.

9. Birthplace **Mo. O**
(City, town, or county) (State or foreign country)

10. Usual occupation **See man**

11. Industry or business **for self**

12. Name **John Foster**

13. Birthplace **Ohio O**
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Carley**

15. Birthplace **Mo O**
(City, town, or county) (State or foreign country)

16. (a) Informant **Alva Foster**

(b) Address **7019 E-1/2 St Terrall**

17. (a) **Burial** (b) Date thereof **Apr-17-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Haven**

18. (a) Signature of funeral director **Max CR Foster**

(b) Address **918 Franklin**

19. (a) **4-17-43** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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. **7019 E. 12th St. Terrace**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **15th**
 year **1943** hour **1:00 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **4-8-43**, 19____, to **4-15-43**, 19____;
 that I last saw him alive on **4-15-43**, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic arteriosclerotic heart disease with myocardial fibrosis and chronic passive congestion of liver**
 Due to **passive congestion of liver**
 Due to **93/8**
 Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: **See above**

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 **James R. Johnson** (M. D. or other) _____
 Address **Med. M. K. U. Gen. Hospital** Date signed _____

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 *Raymond C. B. [unclear]*
Licensed Embalmer No. *2724*
P. O. Address *Kenner 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.