S. No. 2
M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

36170

FILED DEC 6 1945

State File No.

Registration District No. 14 Primary Registration District No. 1002 Registrar's No. 4810

1. PLACE OF DEATH: Jackson
(a) County
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital #2 O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 25 Days
In this community 10 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 824 E. 24th 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) O
If yes, name country

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

4. Sex Male V
5. Color or race Negro
6. (a) Single, widowed, married, divorced Single C
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 7, (Day) 1917 (Year)

8. AGE: Years 28 Months 4 Days ~~14~~ 16 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country) O
10. Usual occupation Unemployed
11. Industry or business

MOTHER FATHER
12. Name Jennils Foster
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
14. Maiden name Ella Smith
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Medical Records Librarian
(b) Address General Hospital #2
17. (a) removal (Burial, cremation, or removal) (b) Date thereof 12/23/45 (Month) (Day) (Year)
(c) Place: burial or cremation Sedalia, Mo.
18. (a) Signature of funeral director Watkins Bros
(b) Address 122 Lydia
19. (a) 12-23-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 23 year 1945 hour 1 minute 50 A. M.

21. I hereby certify that I attended the deceased from October 28, 1945, to November 23, 1945, that I last saw him alive on November 23, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	
(Far Advanced)	
Due to: Psoas Abscess complicating	
Due to:	
Other conditions (Include pregnancy within 3 months of death) 13K	
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 O

23. Signature [signature] (M. D. or other)
Address General Hospital #2 Date signed 12/23/45

(Licensed Embalmer's Statement on Reverse Side)

DEC 20 1965

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 D. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highland

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.