

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

17961

FILED MAY 27 1946

Primary Registration District No.

1132002

Registrar's No.

1131

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town University City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
8524 Richard Ave.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community Life years, months or days)

3. (a) PRINT  
FULL NAMEGeorge W. Foster3. (b) If veteran,  
name warWorld #1.3. (c) Social Security  
No.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Alice Foster  
 6. (c) Age of husband or wife if  
 alive 56 years  
 7. Birth date of deceased August 8, 1889.  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>9</u>	<u>11</u>	hr. min.

9. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)10. Usual occupation Window Display Fixtures11. Industry or business Self12. Name John Foster13. Birthplace Virginia  
(City, town, or county) (State or foreign country)14. Maiden name Unknown15. Birthplace Unknown  
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. Alice Foster(b) Address 8524 Richard Ave.17. (a) BURIAL (b) Date thereof May 22, 1946.  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation LAKE CHARLES CEMETERY18. (a) Signature of funeral director Calvin F. Feutz Funeral Home(b) Address 4828 Natural Bridge Blvd.19. (a) (b) ✓  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
 (c) City or town University City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 8524 Richard Ave.  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 19th  
year 1946 hour 8:30 minute A. M.21. I hereby certify that I attended the deceased from Death without  
medical attendance. 19\_\_\_\_;that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.Immediate cause of death Unknown Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_Of autopsy No autopsy

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?  
\_\_\_\_\_23. Signature Chas. S. \_\_\_\_\_ M.D. or other  
Address 601 Brentwood Blvd. Date signed 5/24/46

JUN 12 1946

JUN 10 1946

JUN 8 1946

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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.....

*John A. Menard*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis 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.**

Registration District No. 317

Primary Registration District No. 2002

Registrar's No. 1131

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town University City  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME George W 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 M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Aug 8 (Month) (Day) (Year)

8. AGE: Years 56 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 15-24-46 (b) E. S. McDevian (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. (Immediate cause of death) \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK

SUPPLEMENTARY

1796d