

No. 2
-12-45
-17-39
X47070

FILED OCT 28 1946
Registration District No. 199

Primary Registration District No. 1002

State File No. _____
Registrar's No. 4326

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 TRINITY LUTHERAN HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 DAY
In this community 41 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY (RURAL)
(If outside city or town limits, write "RURAL")

(d) Street No. 97 1/2 + Mc GEE STREETS
(If rural, give location)

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

3. (a) PRINT FULL NAME LEE FRANK FOSTER

3. (b) If veteran, name war No

3. (c) Social Security No. 703-03 8660

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 13th
year 1946 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from 11 Oct to 12 Oct
that I last saw him alive on 12 Oct
and that death occurred on the date and hour stated above.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. MARGARET FOSTER

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased APRIL 13 1880
(Month) (Day) (Year)

Immediate cause of death Cerebral hemorrhage Duration 27 hrs

8. AGE: Years 66 Months 6 Days 0
If less than one day hr. _____ min. _____

Due to Hypertensive cardio-vascular disease

9. Birthplace LA BETTE CO. KANSAS
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation LOCOMOTIVE ENGINEER

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business K.C. TERMINAL R.R.

Major findings: Of operations 938

12. Name IRVIN W. FOSTER

Of autopsy _____

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

PHYSICIAN _____

14. Maiden name MARY E. WALK

Underline the cause to which death should be charged statistically.

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

22. If death was due to external causes, fill in the following: No

16. (a) Informant MRS. MARGARET FOSTER

(a) Accident, suicide, or homicide (specify) _____

(b) Address 97 1/2 Mc GEE ST. K.C., Mo.

(b) Date of occurrence _____

17. (a) BURIAL (b) Date thereof OCT. 15, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? (City or town) (County) (State) _____

(c) Place: burial or cremation MT. MORIAH CEMETERY

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director D. J. Newcomer

While at work? (Specify type of place) _____

(b) Address 1401 Bush Creek Blvd K.C., Mo.

(e) Means of injury _____

19. (a) 10-15-46 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

23. Signature Caren J. [unclear] (M. D. or other) MD

(Date received local registrar) (Registrar's signature)

Address 7449 Broadway Date signed 14 Oct 46

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

744
1-4:30
L...

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 Bernard L. Loren
Licensed Embalmer No. 4250
P. O. Address NC 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.