

S. No. 2
M-8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1623

FILED FEB 5 1947

Registration District No. 5

Primary Registration District No. 3033

Registrar's No.

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

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community ALWAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County LACLEDE 53
(c) City or town LEBANON MO
(If outside city or town limits, write "RURAL")
(d) Street No. PILWORTH RD.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JAMES MILTON FOSTER
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month JAN day 17
year 1947 hour 7 minute 48 P.M.
21. I hereby certify that I attended the deceased from
1 Dec 1946 to 17 Jan 47
that I last saw him alive on 17 Jan 47, 19____
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife BIRCHIE TRAW
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased JULY 27 1974
(Month) (Day) (Year)

Immediate cause of death
Hypertensive Encephalopathy 6 mo.
Cerebral arteritis 2 yrs.

8. AGE: Years 72 Months 5 Days 20
If less than one day hr. min.

Due to Hypertensive Cardiovascular disease
Due to _____

9. Birthplace CAMDEN CO MO
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy none

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER
12. Name TOM FOSTER
13. Birthplace MO
(City, town, or county) (State or foreign country)
14. Maiden name ZILPA BOSTG.
15. Birthplace MO
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Hugh Gray
(b) Address LEBANON MO

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 _____

17. (a) Burial (b) Date thereof 1-20-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LEBANON MO

(d) Signature of funeral director PALMER'S
(e) Address LEBANON MO

19. (a) Jan 25, 1947 (b) Orla Frankenberg
(Date received local registrar) (Registrar's signature)

23. Signature Paul Jackson (M. D. or other)
Address Lebanon MO Date signed _____

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Received 1/30/47
Laclede County Health Unit
File No. 1-47-11
Date Filed 1/31/47

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. Bahner*
Licensed Embalmer No. *1161*
P. O. Address *Lebanon 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.