

FILED JUL 14 1947

Registration District No. **13**

Primary Registration District No. **4203**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Grundy**
 (b) City or town **Galt**
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Grundy**
 (c) City or town **Galt**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **JOHN WILLIAM FOSTER**

3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **Wht.**
 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Dora Foster**
 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **Oct. 8 1865**
(Month) (Day) (Year)

8. AGE: Years **81** Months **8** Days **19**
If less than one day hr. min.

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

10. Usual occupation **Retired Farmer Farming**

11. Industry or business _____

12. Name **John Foster**

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

14. Maiden name **Martha Jones**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs. Bessie Gibson**

(b) Address **Galt, Mo.**

17. (a) **Burial** (b) Date thereof **June 29 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Deerpark, Milan Mo RFD**

18. (a) Signature of funeral director **Phillipson & Son**

(b) Address **Galt Mo**

19. (a) **6-29-47** (b) **Gene Fair**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **27**
 year **1947** hour **9** minute **50 P** M.

21. I hereby certify that I attended the deceased from **June 24th 1947** to **June 27th 1947**
 that I last saw him alive on **June 24th 1947**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** Duration **3 years**

Due to **Do not know**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **h.p.**

Major findings: Of operations **h.p.**

Of 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? **()**

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

23. Signature **Gene Fair** (M.D. or other) **MD.**

Address **1212 1/2** Date signed **June 27 1947**

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *P. H. Payne Jr*

Licensed Embalmer No. *3400*

P. O. Address..... *Galt*

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.