

FILED FEB 3 1948

Registration District No. 288

Primary Registration District No. 5725

Registrar's No. 265

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

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town Rural Hudson
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (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)

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

3. (a) PRINT FULL NAME Danial T. Foster
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec. day 4
 year 1947 hour 10 minute 30 a.m.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, Single
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
 alive..... years
 7. Birth date of deceased 8 8 1878
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
June 1947, to Dec 4 1947;
 that I last saw him alive on Dec 3 1947;
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 3 26 hr. min.

Immediate cause of death.
Myocarditis with Resuscitation
 Duration See yr.
6 mon.

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

Due to.....
 Due to.....

10. Usual occupation Laborer

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

11. Industry or business.....

Major findings:
 Of operations.....
 Of autopsy.....
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name John Foster
 13. Birthplace Howard Co. Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Sarah Hill
 15. Birthplace Va.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. E. Seeney
 (b) Address Macon, 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?
 (Specify type of place) (e) Means of injury.....

17. (a) Burial (b) Date thereof 12/6/47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Macon, Mo

18. (a) Signature of funeral director Albert Skinner
 (b) Address Macon, Mo

19. (a) 1-12-48 (b) Pete Mcneely
 (Date received local registrar) (Registrar's signature)

23. Signature Howard Miller (M. D. or other)
 Address Macon Date signed 12/6/47

RECEIVED
District Health Officer No. 1
District File Number 148-178
Date Filed JAN 29 1948

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.....

Thos. L. Watt

....., Registered Apprentice No. *37*

working under my personal supervision.

Signed..... *Albert A. Skinner*

Licensed Embalmer No. *751*

P. O. Address..... *Madison*

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.