

No. 300  
1-10-47  
5-17-50  
1-2304

41449

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JAN 11 1949

Registrar's No. 10747

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 month + 14 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Clinton

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

(d) Street No. W.R. (If rural, give location)

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

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Dewey W. Foster

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month December day 11  
year 1948 hour 7 minute 15 A.M.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Josephine

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

7. Birth date of deceased: 62 10 1921  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 27  
1948 to December 11 1948  
that I last saw him alive on December 11 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Gastro-intestinal hemorrhage Duration 8 hrs.

8. AGE: Years Months Days If less than one day

27 0 1 hr. \_\_\_\_\_ min.

Due to Chronic myelogenous leukemia approx 5 months

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

10. Usual occupation Salesman

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

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

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy As above

11. Industry or business Candy

12. Name Charles E Foster

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

14. Maiden name Evelyn White

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Josephine Foster

(b) Address Carlyle Ill.

17. (a) Removal (b) Date thereof 12-11-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenville Ill

18. (a) Signature of funeral home Rowland Mortuary Service

(b) Address 4104 Manchester Ave

19. (a) DEC 13 1948 (b) Job B. Laster  
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury \_\_\_\_\_

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

Address Barnes Hospital Date signed 12/11/48

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

MOTHER FATHER

10747

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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 G. Allen Davis Jr

Licensed Embalmer No. 4053

P. O. Address. OT Lewis 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. JanRegistration District No. 318Primary Registration District No. 1003Registrar's No. 10747

## 1. PLACE OF DEATH:

- (a) County..... 37. LODGE  
 (b) City or town.....  
 (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 NAMEDewey 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..... years

7. Birth date of deceased.....
- see 10
- 
- (Month) (Day) (Year)

8. AGE: Years Months Days (If less than one day  
27 hr. min.

9. Birthplace..... unknown  
 (City, town, or county) (State or foreign country)

## 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) (Burial, cremation, or removal)..... (b) Date thereof.....  
 (Month) (Day) (Year)

- (c) Place: burial or cremation.....  
 18. (a) Signature of funeral director.....  
 (b) Address.....  
 19. (a) (Date received local registrar)..... (b) J. B. Foster  
 (Registrar's signature)  
JAN 18 1948

## 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..... Dec  
 year..... 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....  
 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.....

Duration

- Due to.....  
 Due to.....

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

Major findings:  
 Of operations.....

Of autopsy.....

## 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—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-41449