

FILED JAN 26 1949

STANDARD CERTIFICATE OF DEATH

State File No. 1618

BIRTH NO. _____ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 4848 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. In institution: residence before admission) a. STATE Mo b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Sarcasie		c. CITY (If outside corporate limits, write RURAL and give township) Sarcasie	
c. LENGTH OF STAY (in this place) 30 yrs		d. STREET ADDRESS (If rural, give location) Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home			

3. NAME OF DECEASED (Type or Print) Miss Olive Bayer Foose			4. DATE OF DEATH Jan 15 1949		
5. SEX Fe	6. COLOR OR RACE wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED single	8. DATE OF BIRTH Jan 25 1899		9. AGE (In years last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New Bloomfield Pa		12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME Frederick Foose	13b. MOTHER'S MAIDEN NAME Mary Bayer	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs Effie Haugler		ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 8 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (c) stating the underlying cause last. DUE TO (b) arteriosclerosis			5 yrs
	DUE TO (c) Chronic interstitial nephritis			7 yrs
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1941, to March 1, 1949, that I last saw the deceased alive on Dec 27, 1948, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Helbane M.D.	23b. ADDRESS Sarcasie Mo.	23c. DATE SIGNED 1/14/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1-14-49	24c. NAME OF CEMETERY OR CREMATORY Sarcasie Cem	24d. LOCATION (City, town, or county) (State) Sarcasie Mo
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DATE REC'D BY LOCAL REG. Jan 18, 1949	REGISTRAR'S SIGNATURE P. B. Clinton	FUNERAL DIRECTOR'S SIGNATURE J. Johnson & Sons	ADDRESS Sarcasie Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Sarcelle St

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.