

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33820

State File No. 4498

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4498</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: rank/grade/before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>Unk.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u> <u>98</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>				d. STREET ADDRESS (If rural, give location) <u>3200 Norledge</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Clara</u>		b. (Middle)		c. (Last) <u>Foster</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10 14 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Unk. 1874</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Pensioner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ky.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Record Clerk R.C. Gen. Hosp. #1</u>			
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) <u>Malnutrition and dehydration</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>2865</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		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 <u>Oct. 10, 1949</u> , to <u>Oct. 14, 1949</u> , that I last saw the deceased alive on <u>Oct. 14, 1949</u> , and that death occurred at <u>1:10 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. W. Hart, M.D.</u> (Degree or title)				23b. ADDRESS <u>Med. Dir. Gen'l Hosp.</u>		23c. DATE SIGNED <u>10-15-49</u>	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE <u>10-21-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Kan.</u>	
DATE REC'D BY LOCAL REG. <u>10-21-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>B. C. W. Weelett, C.S.M.</u>			

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

Dr. Clark

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Blaine E. Wickett

Licensed Embalmer No. _____

P. O. Address _____

*4075
L.C. S. 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.