

FILED APR 5 1951

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 7729

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 135

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Scott	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Morley Mo. 1000	
c. LENGTH OF STAY (in this place) 9yr		d. STREET ADDRESS (If rural, give location) 345 N Henderson Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) Littia (Type or Print)			b. (Middle) Foster
c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Mar 29 1951
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 19 1862
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months 9	IF UNDER 1 HR. Hours 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Sammoth Ill		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME A. Cummings		13b. MOTHER'S MAIDEN NAME Don't Know	
14. NAME OF HUSBAND OR WIFE Albert (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME W. E. H. Foster		ADDRESS Cape Girardeau Mo.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Intestinal		DUE TO (b) Carcinoma origin Colon	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Advanced Age		DUE TO (c)	
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 153x	
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)		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 3/15 , 19 50 , to 3/29 , 19 51 , that I last saw the deceased alive on 3/29/51 , 19 51 , and that death occurred at 1:15 P.M. m., from the causes and on the date stated above.			
23a. SIGNATURE W. E. H. Foster		23b. ADDRESS Cape Girardeau Mo.	
23c. DATE SIGNED 3/29/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 1 1951	
24c. NAME OF CEMETERY OR CREMATORY Morley		24d. LOCATION (City, town, or county) (State) Morley Mo.	
DATE REC'D BY LOCAL REG. 3-31-1951		REGISTRAR'S SIGNATURE W. E. H. Foster	
25. FUNERAL DIRECTOR'S SIGNATURE Joe D. Howell		ADDRESS Cape Girardeau	

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

0164

RECEIVED

APR 3 1951

DISTRICT HEALTH OFFICE No.

No.

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 W. H. Estes

Licensed Embalmer No. 8568

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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.