

S. No. 300
V. 10.48

FILED MAY 19 1952

STANDARD CERTIFICATE OF DEATH

State File No. **15785**

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **144**

1. PLACE OF DEATH
 a. COUNTY **Cape Girardeau**
 b. CITY OR TOWN **Cape Girardeau**
 c. LENGTH OF STAY (in this place) _____
 d. FULL NAME OF HOSPITAL OR INSTITUTION **Southeast Missouri Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
 a. STATE **Missouri** b. COUNTY **Cape Girardeau**
 c. CITY OR TOWN **Cape Girardeau, Mo**
 d. STREET ADDRESS (If rural, give location) **400 East Cape Park Drive**

3. NAME OF DECEASED
 a. (First) **SUSAN** b. (Middle) **Cathrine** c. (Last) **Foster**

4. DATE OF DEATH (Month) (Day) (Year)
May 12, 1952

5. SEX **Female**
6. COLOR OR RACE **White**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH
May 21, 1874

9. AGE (In years last birthday) **77** **11** **21**
 Months Days Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife

10b. KIND OF BUSINESS OR INDUSTRY
Indiana

11. BIRTHPLACE (State or foreign country)
Indiana

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13a. FATHER'S NAME
Not Known

13b. MOTHER'S MAIDEN NAME
Not Known

14. NAME OF HUSBAND OR WIFE
James R. Fowler

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.
none

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Louis Morton Fowler **Cape Girardeau**

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) **Complete heart block.**
 ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) **Coronary artery disease**
 DUE TO (c) **Hypertension**
II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.
Thrombocytopenic purpura

INTERVAL BETWEEN ONSET AND DEATH
 ?
 ?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
4201

20. AUTOPSY?
 YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-19, 1951, to May 12, 1952, that I last saw the deceased alive on May 11, 1952, and that death occurred at 5:25 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
Charles F. Wilson M.D.

23b. ADDRESS
717 Broadway Cape Girardeau, Mo

23c. DATE SIGNED
5-15-52

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE
5/14/52

24c. NAME OF CEMETERY OR CREMATORY
Morgan Memorial Park, Advance, Mo.

24d. LOCATION (City, town, or county) (State)
Advance, Mo.

DATE REC'D BY LOCAL REG.
5-15-52

REGISTRAR'S SIGNATURE
C. C. Summer

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Leoyd S. Morgan Advance Mo.

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

164
0

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 _____

William H. Mayan

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed *William H. Mayan*

Licensed Embalmer No. *4640*

P. O. Address *Adelanto, Ind*

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.