

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20446**

FILED JUL 5 1952

2719

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **2719**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (If in place) 33 1/2		d. STREET ADDRESS (If rural, give location) 1627 E. 22nd St. Terr.	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1627 E. 22nd Terrace			

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Louise c. (Last) Foster			4. DATE OF DEATH (Month) (Day) (Year) June 7 52		
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 27, 1919	9. AGE (In years last birthday) 32	IF UNDER 1 YEAR Months	IF UNDER 1 HR. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (If's kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S. A
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13a. FATHER'S NAME Hence Scott	13b. MOTHER'S MAIDEN NAME Irma Roberts	14. NAME OF HUSBAND OR WIFE Milton Foster
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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) No.	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME William King ADDRESS 1627 E. 22nd St.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unknown		INTERVAL BETWEEN ONSET AND DEATH 32 1/2
	ANTECEDENT CAUSES Morbidity 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION History of Alcoholism	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) (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Thos. A. Jones	23b. ADDRESS 1612 E 12th	23c. DATE SIGNED 6/14/52
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24a. BURIAL CREMATION (REMOVAL) (Specify) Burial	24b. DATE 6-14-52	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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DATE REC'D BY LOCAL REG. 6-15-52	REGISTRAR'S SIGNATURE Deraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Marlene Williams ADDRESS 1729 Lytle
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Bruce R. Watkins

Licensed Embalmer No. 4500

P. O. Address 18th & Benton

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.