No. 300
10.48

FILED OCT 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30431

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. _____

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

1. PLACE OF DEATH
a. COUNTY: Howell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Plains
c. LENGTH OF STAY (in this place): 1 wk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Christa Hogan Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Texas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cabool 1070
d. STREET ADDRESS (If rural, give location): /

3. NAME OF DECEASED (Type or Print)
a. (First): Ruth
b. (Middle): Ann
c. (Last): Foster

4. DATE OF DEATH (Month) (Day) (Year): 10 - 5 - 54

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3-16-1899
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cabool, Mo.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Sam Cunningham
13b. MOTHER'S MAIDEN NAME: Elizabeth Fry
14. NAME OF HUSBAND OR WIFE: Chas. Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 487-34-6746
17. INFORMANT'S SIGNATURE OR NAME: Charles Foster
ADDRESS: Cabool

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: 10 mos.

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.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 170 X
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) m.:
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* Dec 5, 1953, *to* Oct 3, 1954, *that I last saw the deceased alive on* Oct 3, 1954, *and that death occurred at* 11:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Garrett Gogg Jr MD
23b. ADDRESS: Cabool Mo
23c. DATE SIGNED: Oct 7/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-8-54
24c. NAME OF CEMETERY OR CREMATORY: Cabool Cemet.
24d. LOCATION (City, town, or county) (State): Cabool, Mo.

DATE REC'D BY LOCAL REG.: OCT 13 1954
REGISTRAR'S SIGNATURE: Clyde A. Bridges
25. FUNERAL DIRECTOR'S SIGNATURE: Elliott-Gentry, **ADDRESS**: Cabool, Mo

(Licensed Embalmer's Statement on Reverse Side)

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 James L. Henry

Licensed Embalmer No. 4718

P. O. Address Cabool, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.