

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18379**
Registrar's No. **85**

FILED JUL 11 1955

BIRTH NO. **35150-55** REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **3021**

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Grundy	
b. CITY (If outside corporate limits, write RURAL and give township) Trenton		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Galt 0400 d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Cullers Hospital		e. STREET ADDRESS (If rural, give location) Rt. R.F.D. Myers Twp.	

3. NAME OF DECEASED (Type or Print) a. (First) Infant son of Mrs. Donald Wayne Foster b. (Middle) c. (Last) Foster		4. DATE OF DEATH (Month) (Day) (Year) 6 19-1955	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 6-19-1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Cullers Hospit Trenton Mo
			12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Donald Wayne Foster	13b. MOTHER'S MAIDEN NAME Virginia Ruth Sloan	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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Donald W Foster
		ADDRESS Galt 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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured bag of waters - Premature Birth		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 776X 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	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 **6-19-1955**, to **6-19-1955**, that I last saw the deceased alive on **6-19-1955**, and that death occurred at **m.**, from the causes and on the date stated above.

23a. SIGNATURE BH Cullers (Degree or title) M.D.	23b. ADDRESS Trenton, Mo.	23c. DATE SIGNED 6-20-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-20-1955	24c. NAME OF CEMETERY OR CREMATORY Half Rock Cem.
		24d. LOCATION (City, town, or county) (State) Spickard Mo.
DATE REC'D BY LOCAL REG. 6-20-55	REGISTRAR'S SIGNATURE Drene Jain	25. FUNERAL DIRECTOR'S SIGNATURE RK Payne
		ADDRESS Trenton Mo

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 Not Embalmed, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed PK Payne Jr
Licensed Embalmer No. 34

P. O. Address Galt

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.