

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32263**

FILED NOV 7 1955

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1144**

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan					
b. CITY OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 45 yrs.		c. CITY OR TOWN St. Joseph		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1024 North 2nd Street				e. STREET ADDRESS (If rural, give location) 1024 North 2nd Street					
3. NAME OF DECEASED (Type or Print) a. (First) LAVONE			b. (Middle) _____		c. (Last) FOSBURGH		4. DATE OF DEATH (Month) (Day) (Year) Oct. 26 1955		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 25, 1876		9. AGE (In years last birthday) 79	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) At Home			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Hopkinton Iowa		12. CITIZEN OF WHAT COUNTRY? U S A		
13a. FATHER'S NAME Charles Colyar			13b. MOTHER'S MAIDEN NAME Sophia unk		14. NAME OF HUSBAND OR WIFE Ogden D. Fosburgh				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ogden D. Fosburgh ADDRESS St. Joseph, 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, asthma, 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) Arteriosclerotic heart disease years				DUPLICATE (b) General arteriosclerosis years					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE (c) none					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				none				4200	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION no operation				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? no injury					
22. I hereby certify that I attended the deceased from Oct 20, 1955 to Oct 26, 1955 , that I last saw the deceased alive on Oct 25, 1955 and that death occurred at 8:00 P. m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Homeliney m d				23b. ADDRESS 214 Kuylenburg Plaza St. Joseph, Mo.		23c. DATE SIGNED Oct 27, 55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 29, 1955	24c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph Missouri				
DATE REC'D BY LOCAL REG. Oct 31, 1955		REGISTRAR'S SIGNATURE Eather M. Allison		GENERAL DIRECTOR'S SIGNATURE Stamey ADDRESS Funeral Home St. Joseph, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed *Charles E. Bennett*.....

Licensed Embalmer No. *416*

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.