

FILED AUG 5 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23827

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

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>4078</u>		Registrar's No. <u>368</u>	
1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CAPE Gir</u>			
b. CITY OR TOWN <u>DELTA</u>		c. LENGTH OF STAY (in this place) <u>69 YRS.</u>		c. CITY OR TOWN <u>DELTA</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>At Home - IN TOWN</u>				e. STREET ADDRESS (If rural, give location) <u>_____</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Willie</u> b. (Middle) <u>(NMN)</u> c. (Last) <u>FOSTER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 26, 1957</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>NOV. 27, 1887</u>	
9. AGE (In years last birthday) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELTER-INSOLE DEPT. (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE FACTORY (REAR)</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ORAN, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOHN (NMN) FOSTER</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISE (NMN) COX</u>		14. NAME OF HUSBAND OR WIFE <u>ANNIE LETA FOSTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>491-18-7672</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ANNIE LETA FOSTER - DELTA Mo.</u> ADDRESS <u>_____</u>			
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) <u>Coronary thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Obese</u> DUE TO (c) <u>?</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <u>2</u> 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) <u>4201</u>			
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 <u>June 25, 1957</u> , to <u>July 26, 1957</u> , 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 <u>Wm. D. ...</u>				23b. ADDRESS <u>Delta Mo</u>		23c. DATE SIGNED <u>July 25, 1957</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>7-29-57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MORGAN MEMORIAL CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ADVANCE, MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>7-29-57</u>		REGISTRAR'S SIGNATURE <u>C. C. Summers</u>		FUNERAL DIRECTOR'S SIGNATURE <u>BISPLINGHOFF FUNERAL HOME</u>		ADDRESS <u>CHAFFEE, Mo</u>	

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 *Jack J. Burnett*

Licensed Embalmer No. *447*
P. O. Address *Chaffee, M.*

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.