

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25367

STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 286

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Marion</u>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u> |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>Hannibal</u>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <u>Hannibal</u>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence 1322 Vermont</u>  |   |   | Length of stay in 1b  |  | d. STREET ADDRESS (If outside, give location) <u>1322 Vermont</u>                    |
| 3. NAME OF DECEASED (Type or print)<br><u>ADDISON HENRY FOSTER</u>   |   |   | 4. DATE OF DEATH<br><u>July 29, 1957</u>  |  |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>February 18, 1885</u>                               |  |
| 9. AGE (In years last birthday)<br><u>72</u>   | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u> | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Ice Dealer</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Monroe City Missouri</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U S A</u>   |
| 13. FATHER'S NAME<br><u>Not given</u>  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Not given</u>  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   | 17. INFORMANT<br><u>Mrs. A. H. Foster</u> Address <u>Hannibal Missouri</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>terminal pneumonia</u><br>DUE TO (b) <u>Congestive heart failure</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Carcinoma of breast</u> |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u><br><u>3 weeks</u>                  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY<br>Hour - Month, Day, Year<br>a. m. p. m.  |   |   |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20f. CITY, TOWN, OR LOCATION<br><u>Hannibal Marion Mo.</u>                 |  |
| 21. I attended the deceased from <u>7/3/57</u> to <u>7/28/57</u> and last saw her/him alive on <u>7/28/57</u><br>Death occurred at <u>3:10 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.   |   |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><u>S. H. Weetterschein M.D.</u>  |   |   | 22b. ADDRESS<br><u>Hannibal Mo</u>  |  | 22c. DATE SIGNED<br><u>7/30/57</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE<br><u>8-1-57</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Grandview Burial Park, Hannibal, Mo.</u>   |   | 23d. LOCATION (City, town, or county) (State)                              |  |
| 24. FUNERAL DIRECTOR<br><u>Wesley Paul Smith Hannibal Mo</u>   |   | ADDRESS   | 25. DATE RECD. BY LOCAL REG.<br><u>7-31-57</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Dr. E. M. Tucker by W. P. Tucker</u>       |  |

MEDICAL CERTIFICATION

diseases in Part I must be causally related. Caroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED DEC 9 1957  
MARION CO. HEALTH DEPT.  
DATE FILED DEC 9 1957

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *W. Crawford Smith*  
Licensed Embalmer No.....

P. O. Address Hannibal Mi

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.