

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030393

STATE FILE NUMBER 7857

FILED AUG 28 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN East St. Louis 8120		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 34 St. Mary's Infirmary		Length of stay in 1b 3 Weeks	d. STREET ADDRESS (If outside, give location) 32 213 North 7th Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE LAST ROXIE FOSTER			4. DATE OF DEATH Month Day Year August 9, 1958		
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1900	9. AGE (In years last birthday) 57	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days 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 None	11. BIRTHPLACE (City and state or country) Marx, Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Walter Ross		13b. MOTHER'S MAIDEN NAME Malinda (Unknown)		14. NAME OF HUSBAND OR WIFE William Foster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address 213 No. 7th St. St. Louis, Ill. Michael Holmes		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure acute myocardial failure Stokes-Adams syndrome DUE TO (b) STOKES ADAMS SYNDROME Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH acute
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pt has gall bladder operation 586x Pt. had gall bladder operation					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 2			
20c. TIME OF INJURY Hour Month, Day, Year 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 COUNTY STATE	
21. I attended the deceased from 7/17/58 to 8/9/58 and last saw her alive on 8/9/58 Death occurred at 8120 N 7th St on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Edgar F. Woodson (Name or title) Edgar F. Woodson M.D.			22b. ADDRESS E. St. Louis, Ill. 930 N. LINDA St		22c. DATE SIGNED 8/2/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8/9/58	23c. NAME OF CEMETERY OR CREMATORY Booker Washington		23d. LOCATION (City, town, or county) (State) Centreville Township, Illinois
24. FUNERAL DIRECTOR Marion E. Officer 2114 Missouri Av. E. St. Louis, Illinois			25. DATE RECD. BY LOCAL REG. AUG 12 1958	26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

(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
Signature of Student Embalmer

Signed *Frank Proff*

Licensed Embalmer No. *356*

P. O. Address *St. Louis, Mo.*

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.