

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037135

STATE FILE NUMBER

Health,  
& Welfare  
Public  
Service

S. 300  
7. 1-56

MA  
O  
All  
No symptoms will be listed. All  
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. <u>209</u>		Primary Registration District No. <u>3043</u>		Registrar's No. <u>354</u>	
1. PLACE OF DEATH a. COUNTY <u>MARION</u> b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits TOWN <u>HANNIBAL</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. FULL NAME OF (IF NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>ST. ELIZABETH HOSP.</u> <u>16 DAYS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MARION</u> c. CITY OR TOWN <u>HANNIBAL</u> Inside Limits <u>0644</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET (If outside, give location) Reside on Farm ADDRESS <u>2312 Spruce ST.</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>FOSTER L. WASHINGTON</u>			4. DATE OF DEATH Month Day Year <u>10 - 26 - 58</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27 1884</u>	9. AGE (In years last birthday) <u>74</u> IF UNDER 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) <u>PORTER</u>		100. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>	11. BIRTHPLACE (City and state or country) <u>HANNIBAL MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>HENRY WASHINGTON</u>			14. MOTHER'S MAIDEN NAME <u>MARY MITCHELL</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>486-18-7663</u>	17. INFORMANT <u>Willie Washington</u> Address <u>#4 HOGG ROW</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Cerebral hemorrhage; right hemiplegia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>16 days</u> <u>16 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? 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.) <u>331 X</u>		
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 <u>8-16-55</u> to <u>10-26-58</u> and last saw <sup>her</sup> him alive on <u>10-26-58</u> Death occurred at <u>11:25</u> <u>P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>0</u>			22b. ADDRESS <u>M.D. 100 N. Sixth, Hannibal, Mo.</u>		22c. DATE SIGNED <u>10-28-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-29-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cemetary</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Mo</u>
24. FUNERAL DIRECTOR <u>W.R. Sephus</u>		ADDRESS <u>Hannibal Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luckey by M. C. Fisher</u>

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED NOV 5 1950  
MARION CO. HEALTH DEPT.  
DATE FILED NOV 5 1950

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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 embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student .....

Signature of Student Embalmer

Signed *W. R. Sephus* .....

Licensed Embalmer No. *34*

P. O. Address *Marion, Mo.*

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.