

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000451

STATE FILE NUMBER

FILED JAN 15 1959

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 3

300
1-57

1. PLACE OF DEATH a. COUNTY Callaway		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Callaway	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fulton	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Callaway Hospital	Length of stay in lb 4 Days	d. STREET ADDRESS (If outside, give location) 914 West Ave	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Effie Middle Jane Last Foster	4. DATE OF DEATH Month Jan Day 8 Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1879	9. AGE (In years) 79 (birth day)	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Callaway County, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.S.
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13a. FATHER'S NAME Addison Boofer	13b. MOTHER'S MAIDEN NAME Mary Ellen Swan	14. NAME OF HUSBAND OR WIFE Joe Foster
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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. 486-12-5639	17. INFORMANT Mrs. Virgil Strickland, Fulton, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA	INTERVAL BETWEEN ONSET AND DEATH 24-36 hr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) RENAL SHUT DOWN	} 1 WK
DUE TO (c) MACROCYTIC ANEMIA + CONGESTIVE HEART FAILURE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ASTHMA	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Fulton	COUNTY Callaway	STATE Mo
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20d. INJURY OCCURRED WHILE AT <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 Fulton	COUNTY Callaway	STATE Mo
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21. I attended the deceased from Death occurred at 5:30 AM on 3 JAN. 59 to 8 JAN 59 and last saw her/him alive on 7 JAN 59 m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE George W. Grace, MD. (Degree or title)	22b. ADDRESS 607 Court St. Fulton, Mo	22c. DATE SIGNED 1-9-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan-11-1959	23c. NAME OF CEMETERY OR CREMATORY New Bloomfield Cem.	23d. LOCATION (City, town, or county) (State) New Bloomfield Mo
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24. FUNERAL DIRECTOR Wallace Funeral Home, Fulton, Mo	ADDRESS Fulton, Mo	25. DATE RECD. BY LOCAL REG. Jan. 9. 1959	26. REGISTRAR'S SIGNATURE Maretha Lawrence
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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.

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 *Hector R. Moore*

Licensed Embalmer No. *4996*
P. O. Address *Fulham, Ma.*

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.