

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002944
STATE FILE NUMBER 326

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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-57
23
173
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|--|-----------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Saint Louis, | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Length of stay in 1b | d. STREET ADDRESS 2019 1908 Coode Avenue | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELIZA MAE FOSTER | | | 4. DATE OF DEATH Month Day Year JANUARY 8, 1959 | | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-17-1924 | 9. AGE (In years last birthday) 34 | IF UNDER 1 YEAR Months 8 Days 12 |
| 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) Missouri | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Joe Kay | | 13b. MOTHER'S MAIDEN NAME Charlotte Washington | | 14. NAME OF HUSBAND OR WIFE Wilbert Foster | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. ? | 17. INFORMANT Address Wilbert Foster 1908 Coode Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 DAY |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) HYPERTENSIVE VASCULAR DISEASE DUE TO (c) 330X | | | | | UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | |
| 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 COUNTY STATE | |
| 21. I attended the deceased from AUG 13, 1953 to JAN. 8, 1959 and last saw her alive on JAN. 8, 1959 Death occurred at 8:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) C. P. Vermillion, M. D. | | | 22b. ADDRESS BARNES HOSPITAL | | 22c. DATE SIGNED 1/8/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 1/11/59 | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) Columbia, Missouri |
| 24. FUNERAL DIRECTOR Address Ellis Funeral Home, 2820 Stoddard St | | | 25. DATE RECD. BY LOCAL REG. JAN 12 '59 | 26. REGISTRAR'S SIGNATURE J. Earl Smith MD | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All causes 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 *Arthur E. Calk*

Licensed Embalmer No. *4198*
P. O. Address *.....*

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.