

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020688

STATE FILE NUMBER

FILED JUN 29 1959

Registration District No. 44 Primary Registration District No. 5245 Registrar's No. 36

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Chariton</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Chariton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Keytesville Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Keytesville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4-Miles W. of Key.</u>		Length of stay in lb <u>90-Years</u>	d. STREET ADDRESS (If outside, give location) <u>4-Miles W of Keytesville</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>George McClellan Foster</u>			4. DATE OF DEATH Month Day Year <u>June 22nd, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Sep. 19th, 1864</u>	9. AGE (In years last birthday) <u>94</u>	FUNDER 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>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>	11. BIRTHPLACE (City and state or country) <u>Clayton Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Henry Clay Foster</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Owens</u>		14. NAME OF HUSBAND OR WIFE <u>Viola Foster</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>None</u>		17. INFORMANT Address <u>Mrs. Viola Foster Keytesville, Mo.</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>Gangrene of left foot</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Atherosclerosis of left leg & foot</u> DUE TO (c) <u>Generalized atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4501</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 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>Nov 12, 1958</u> to <u>June 22, 1959</u> and last saw him alive on <u>June 22, 1959</u> Death occurred at <u>1:30 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>H. E. G. Smith, M.D.</u>			22b. ADDRESS <u>Salisbury, Mo</u>		22c. DATE SIGNED <u>6/23/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 25th, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Keytesville, Mo.</u>	
24. FUNERAL DIRECTOR <u>H. E. G. Smith</u>		ADDRESS <u>Keytesville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-23-59</u>	26. REGISTRAR'S SIGNATURE <u>J. W. Hawkins</u>

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.

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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 *A. D. Grunett*

Licensed Embalmer No. *3046*

P. O. Address *Key to will*

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.