

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-011933

AMENDED

DATE AMENDED

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BY AFFIDAVIT OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 824 STATE FILE NUMBER

1. PLACE OF DEATH 0 1961

a. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) Ferguson OR TOWN Ferguson Length of stay in 1b 7 yrs.

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 832 Carson Road Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY St. Louis

c. CITY OR TOWN FERGUSON Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 832 Carson Road Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First DANIEL Middle K. Last FOSTER

4. DATE OF DEATH March 26, 1961 Month March Day 26 Year 1961

5. SEX male

6. COLOR OR RACE white

7. Married Never Married Widowed Divorced

8. DATE OF BIRTH Nov. 12, 1882

9. AGE (last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) night watchman

10b. KIND OF BUSINESS OR INDUSTRY H. Paul & Son

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Joseph Kelly

13b. MOTHER'S MAIDEN NAME Elizabeth Richter

14. NAME OF HUSBAND OR WIFE Anna Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

17. INFORMANT Address Anna Foster 832 Carson Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 48 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arterio-sclerosis

DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Rheumatoid Arthritis.

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 19 38 to 19 61 and last saw him alive on 3/25/61. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Kellian O. Mansley M.D.

22b. ADDRESS 231 Northland Medical Bldg

22c. DATE SIGNED 3/25/61 (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE Mar 29 1961

23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.

23d. LOCATION (City, town, or county) St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS Bromschwig and Son W Florissant 4746

25. DATE RECD. BY LOCAL REG. 3-27-61

26. REGISTRAR'S SIGNATURE J. C. Mansley M.D.

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 Jam Bunsley

Licensed Embalmer No. 3653

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.