

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

81 -62-039517
STATE FILE NUMBER

Registration District No. 217 Primary Registration District No. 3045 Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED OCT 24 1962		1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Charleston, Missouri</u>		Length of stay in 1b		c. CITY OR TOWN <u>Linton, Indiana</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mitchell Hotel</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>69 - 3rd St.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Meredith</u> Last <u>Foust</u>			4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1962</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>6/12/1914</u>	9. AGE (last birthday) <u>48</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentistry</u>		11. BIRTHPLACE (City and state or country) <u>Huntington, Ind. USA</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Price W. Foust</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Shock</u>	
14. NAME OF HUSBAND OR WIFE <u>Sarabelle Foust</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes U.S. Navy</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Sarabelle Foust</u>		Address <u>Linton, Indiana</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>Overdose of sleeping pill and Suffocation</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>Mr. Foust checked in hotel for one night and took an overdose of sleeping pills and put a plastic pillow case over his head and zipped us same and was found the following day</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ After death as <u>Coroner</u> and last saw her/him alive on _____ Death occurred at <u>Friday ????????</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) <u>[Signature] Coroner</u>			22b. ADDRESS <u>Charleston, Missouri</u>		22c. DATE SIGNED <u>10/20/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/23/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town, or county) (State) <u>Linton, Indiana</u>	
24. FUNERAL DIRECTOR <u>McMikle Charleston, Missouri</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-21-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

OCT 26 1962

Permit received
10-21-62
JH

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 Edwin McMillan

Licensed Embalmer No. 4695

P. O. Address Charleston, 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.