

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-025488**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 311 Primary Registration District No. 3058 Registrar's No. 5-a

**FILED JUN 17 1963**

VS 300  
Rev. 4/59

1 0928  
2 400X  
3  
4 0  
5 1  
6  
7 1  
8 1  
9 581.0  
10  
11  
12 1-0  
13 5-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Length of stay in 1b <b>5 weeks</b>	c. CITY OR TOWN <b>Overland</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3711 Edmundson Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William E. Foster</b>			4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinery</b>	9. AGE (last birthday) <b>55</b> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (City, and state or country) <b>Chicago, Illinois</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>James Clever Foster</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Marie Crowley</b>	14. NAME OF HUSBAND OR WIFE <b>Leona P. Foster</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Leona P. Foster 3711 Edmundson Rd.</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY)			INTERVAL BETWEEN ONSET AND DEATH <b>7-10 days</b>
IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION - LEFT ANTERIOR</b>			
DUE TO (b) _____			
DUE TO (c) <b>CIRRHOSIS OF LIVER</b>			
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 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 _____ a.m. _____ p.m. Month, Day, Year _____	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 <b>MAY 4, 1963</b> to <b>9 June 1963</b> and last saw <sup>her</sup> him alive on <b>8 June 1963</b> Death occurred at <b>H A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. G. Mullerky, M.D.</b>		22b. ADDRESS <b>8711 St. Charles Rd. (14)</b>	22c. DATE SIGNED <b>6/10/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/12/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
24. FUNERAL DIRECTOR <b>Collier Mortuary</b>		ADDRESS <b>St. Ann, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-10-63</b>
26. REGISTRAR'S SIGNATURE <b>Palmyra Stewart</b>			<b>Mabel Fennellett Dep</b>

JUN 6 1961

**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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann 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.