

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

Do not use this space.

13109

**1. PLACE OF DEATH**

County.....  
 Township.....  
 City..... *W.ouri*

Registration District No. **791**  
 Primary Registration District No. **1003**

File No.....  
 Registered No. **3408**  
 St..... Ward.....

**2. FULL NAME**

*Charles Foster*

(a) Residence. No. *2748 Utah* St., *24* Ward.

(Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town, where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Dottie Foster*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr 24 1862*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*64 11 12*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Track Trowman*  
 (b) General nature of industry, business, or establishment in which employed (or employee) *Railroad*  
 (c) Name of employer *TRRA*

9. BIRTHPLACE (CITY OR TOWN) *Rivdale Ill*  
 (STATE OR COUNTRY)

10. NAME OF FATHER *Geo. Foster*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *England*  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *" "*  
 (STATE OR COUNTRY)

14. INFORMANT *Lena Foster*  
 (Address) *2748 Utah*

15. FILED *8-10-27* *May 6 Starnes*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-6-1927*

17. I HEREBY CERTIFY, That I attended deceased from *line* *3-30* 19*27* to *4-6* 19*27* that I last saw ~~him~~ alive on *4-5* 19*27*, and that death occurred, on the date stated above, at *6:45 a.m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*23rd Chronic Pulmonary Tbc*

CONTRIBUTORY (SECONDARY) *age*  
 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH. *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *Physical Exam*

(Signed) *Bernard S. Sturkey*, M. D.

*4/7/1927* (Address) *2024 So Jefferson*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *No. Crematory* DATE OF BURIAL *4-9-1927*

20. UNDERTAKER *W. Schumacher* ADDRESS *So. 13th*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1910-1915-1920-1925-1930-1935-1940-1945-1950-1955-1960-1965-1970-1975-1980-1985-1990-1995-2000-2005-2010-2015-2020-2025-2030-2035-2040-2045-2050-2055-2060-2065-2070-2075-2080-2085-2090-2095-2100

