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

Do not use this space.
30334

File No. 91
Registered No.

1. PLACE OF DEATH
County H.well
Township Howell
City West Plains Mo. (No. ..., ... St. ... Ward)
Registration District No. 3824
Primary Registration District No. 4227

2. FULL NAME Lewis Kenneth Foster

(a) Residence. No. ... St., ... 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan.16.1924.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
4	7	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) New Mexico

PARENTS
10. NAME OF FATHER Lewis O.Foster
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER Effie M.Koelling
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri.

14. INFORMANT Mrs Lewis O.Foster
(Address) Cedarvale New Mexico.

15. FILED 9-1-1928 O.A. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/1/1928. 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1928, to Sept 1 1928, that I last saw him alive on Aug 31, 1928 and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremia
Colitis
114 (duration) ... yrs. ... mos. 14 ds.
CONTRIBUTORY (SECONDARY) ...
... (duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH? ...
DID AN OPERATION PRECEDE DEATH? No DATE OF ...
WAS THERE AN AUTOPSY? ~~Clinical~~ No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) J. D. Lynn M.D
9-1-1928 (Address) West Plains, Mo

*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 ~~Pomona Mo~~ Pomona Mo. — DATE OF BURIAL 9-2-1928

20. UNDERTAKER Geo. Q. Stapp — ADDRESS West Plains Mo

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.