

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

Do not use this space.

8 1929

40287

1. PLACE OF DEATH *Greene* Registration District No. *318*
 County *Greene* Township *Springfield* Primary Registration District No. *R # 1 5439*
 City *Springfield* (No. *R # 1*) St. _____ Ward _____

2. FULL NAME *Levis 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No. _____
 Registered No. *862*
 St. _____ Ward _____

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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 26 1898*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
29 11 15

8. OCCUPATION OF DECEASED *Farmer*
 (a) Trade, profession, or particular kind of work *131 107*
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 12 1928*

17. I HEREBY CERTIFY That I attended deceased from *Dec 15 1928* to *Dec 10 1928*, that I last saw him alive on *Dec 8 1928*, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
1292 (duration) *6* yrs. _____ mos. _____ da.
 CONTRIBUTORY *Pneumonia* (SECONDARY)
terminal (duration) _____ yrs. _____ mos. *3* da.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

20. WAS THERE AN AUTOPSY? *No*

21. WHAT TEST CONFIRMED DIAGNOSIS? *Robert Flynn* (Signed) _____ M. D.
 _____ No. 19 _____ (Address) *Springfield 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.

9. BIRTHPLACE (CITY OR TOWN) *Mo.* (STATE OR COUNTRY) _____

10. NAME OF FATHER *Sheridan Foster*

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

12. MAIDEN NAME OF MOTHER *Clara Swiggen*

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

14. INFORMANT *Sheridan Foster* (Address) *Springfield, Mo.*

15. FILED *12/12 1928* *V. E. Horstmas* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Bellview Cemetery* DATE OF BURIAL *Dec 12 1928*

20. UNDERTAKER *J. M. Klingner & Co. 424 E. Conl* ADDRESS *Springfield 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.

