

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

Do not use this space.

42523

**1. PLACE OF DEATH**

County.....

Registration District No.....

**791**

Township.....

Primary Registration District No.....

**1003**

City *St. Louis Mo.* (No. *City Hosp*)

File No.....

Registered No.....

St..... Ward)

**2. FULL NAME**

*Frank B Foster*

(a) Residence. No. *4666 Ashland Ave* St. *6* 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Male*

*White*

*Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 15, 1860*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*69 6 -*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Retired Salesman*

(b) General nature of industry, business, or establishment in which employed (or employer) *American Packing Meats Co.*

(c) Name of employer *Meats Co.*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ills.*

10. NAME OF FATHER *Don't know.*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know.*

12. MAIDEN NAME OF MOTHER *Don't know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Don't know.*

14. INFORMANT *Oliver P. Peters* (Address) *4666 Ashland Ave.*

15. FILED *DEC 31 1929* *May Starcher* REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 15 1929*

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at *10:25 AM* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*By postmortem*  
*Pneumonia*  
*Fracture femur struck by angle* (duration)..... yrs..... mos..... ds.

CONTRIBUTORY (SECONDARY) *regarding St. Louis Mo.* (duration)..... yrs..... mos..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Wm V. Dewet* M.D.

*12/17, 1929* (Address) *Coroner*

\*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 *St Peters* DATE OF BURIAL *Dec 18 1929*

20. UNDERTAKER *Hy Leidner and Co. St. Market* ADDRESS *1417*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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