

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

Do not use this space.

13-882-8  
C

JUN 25 1930

**1. PLACE OF DEATH**

County Greene Registration District No. 318  
Township Springfield Primary Registration District No. 2001  
City Springfield (No. 529) St. W. Turner

File No. ....  
Registered No. 410  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 529 W. Turner 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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 12 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
70 9 18

**8. OCCUPATION OF DECEASED**

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

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

10. NAME OF FATHER Arden W. Foltz

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

12. MAIDEN NAME OF MOTHER Annie S. Cain

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

14. INFORMANT Mary A. Palmer  
(Address) Springfield, Mo.

15. FILED 9/1, 19. 30 G. S. Sharp  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-30-1930

17. I HEREBY CERTIFY, That I attended deceased from 5-29-1930 to 5-30-1930 that I last saw him alive on 5-30-1930, and that death occurred, on the date stated above, at 1220 H. m.

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

Senility  
16a

(duration) 2 yrs. 14 mos. 14 ds.

CONTRIBUTORY (SECONDARY) General debility  
(duration) 2 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) C. E. Zeller M. D.

5-30, 1930 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Green Lawn 1930  
20. UNDERTAKER G. M. Klingner 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.

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