

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

Do not use this space.

16493

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis*

Registration District No. *791*
Primary Registration District No. *1703*
No. *Park Plaza Hotel*

File No.....
Registered No. *5014*
St. Ward)

2. FULL NAME

Turner S. Foster
(a) Residence, No. *Park Plaza Hotel*, St. *12* Ward.

(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 *Male*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 25 1931*

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

17. I HEREBY CERTIFY, That I attended deceased from *11-2-1929* to *April 25 1931*, that I last saw him alive on *April 21 1931*, and that death occurred, on the date stated above, at *4:15 A. m.*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 11-1849*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *82 3 14*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Stomach
H.B.

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

(duration) yrs. *3* mos. ds.

9. BIRTHPLACE (CITY OR TOWN) *Flomenville*
(STATE OR COUNTRY) *Alabama*

CONTRIBUTORY (SECONDARY) *4-6-1931*
(duration) yrs. mos. ds.

10. NAME OF FATHER *Turner S. Foster*

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

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

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....
WAS THERE AN AUTOPSY? *no*

12. MAIDEN NAME OF MOTHER *Annie Wilson*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Unknown*
(STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS? *X-ray*
(Signed) *Anthony B. Day*, M. D.
4-25 1931 (Address) *2720 Washington Blvd.*

14. INFORMANT *Dr. Jerome Jones*
(Address) *Denning Co.*

*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.

15. FILED *27 1931*
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Walsh Hill Cemetery* DATE OF BURIAL *Apr 27 1931*
20. UNDERTAKER *Wagoner* ADDRESS *3621 Olive*

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



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