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.

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No. 4031

Township — Primary Registration District No. 1001 — Registered No. 196

City St. Joseph (No. Missouri Meth. Hospital St. Ward)

2. FULL NAME Raymond Victor Foster

(a) Residence, No. St., Ward. Wichita Kansas
(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)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 29, 1897

7. AGE: YEARS 36 — MONTHS 5 — DAYS 18 — If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Half Rock Missouri

FATHER
13. NAME Ephriam H. Foster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Unknown

MOTHER
15. MAIDEN NAME Martha Willard
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Prinston Missouri

17. INFORMANT (ADDRESS) Mrs Marthale Brown 1213 Main st St Joseph Mo.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Memorial Park Cem.
PLACE St Joseph Mo. DATE Febr. 2-20 1934

19. UNDERTAKER (ADDRESS) A. O. Sidenfaden 1802 Union st St Joseph Mo.

20. FILED FEB 19 1934 John R. Bender Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 17, 1934

22. I HEREBY CERTIFY, That I ~~attended deceased~~ viewed remains from Feb. 17, 1934, to , 19

I last saw him alive on , 19 Death is said to have occurred on the date stated above, at 1 A m.

The principal cause of death and related causes of importance were as follows:

Fractured Skull & left side crushed (accidental) passenger in automobile

Date of onset

Other contributory causes of importance:
Auto collision on 71 12 miles south of St Jos

Name of operation none Date of

What test confirmed diagnosis? Eyewitness Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 2/17, 1934
Where did injury occur? Platte County (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Public Place
Manner of injury Auto collision
Nature of injury Fractured Skull (left side crushed)

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Forrest Thomas Dooner M.D.
(Address) 731 Faaron