

FEB 17 1937

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

Do not use this space.

1098

1. PLACE OF DEATH
 County Holt Registration District No. 373
 Township Primary Registration District No. 142192
 City Oregon (No.) St. Ward)
 2. FULL NAME William Calvin 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 9 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) Feb 6, 1875
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 11 4

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

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

10. NAME OF FATHER Samuel Foster
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
 12. MAIDEN NAME OF MOTHER Helen M. Williams
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Jessie Foster
 (Address) Oregon Mo.

15. FILED 1-11-37 19 37 W. S. Charles
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10, 1937
 17. I, Dr. J. H. ... HEREBY CERTIFY That I attended deceased from admission to Christian ... (date) 19... and that death occurred, on the date stated above, at 12:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia - Bronchial
 (duration) 19 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Syphilis
 (duration) 19 yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED infection about two years ago

IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? No DATE OF.....
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) Dr. J. H. ... M. D.
County Health Officer
Oregon Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oregon Mo. DATE OF BURIAL 1-11 1936

20. UNDERTAKER Foster Pettigrove ADDRESS Oregon 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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