REC'D JAN 14 1939

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

43087
Do not use this space.

1. PLACE OF DEATH
(a) County GREENE — Registration District No. 318
(b) Township — Primary Registration District No. 2001 — Registered No. 951
(c) City SPRINGFIELD — (d) Street No. Burge Hosp. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME William Emmett Foster
(a) Residence, No. R.F.D. #1 St. Route #1
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Maynie M. Foster
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 23 1883
7. AGE — Years 55 — Months 6 — Days 7 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. W. P. A. Worker
9. Industry or business in which work was done, as saw mill, bank, etc. U.S.A. Projects
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) St Francois Co. Mo.

FATHER
13. NAME Samuel M. Foster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
15. MAIDEN NAME Sarah Harris
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT Maynie M. Foster
(ADDRESS) Springfield Mo. R#1

18. BURIAL, CREMATION, OR REMOVAL
PLACE Rose Hill DATE Dec 12 1938

19. FUNERAL DIRECTOR (NAME) J. M. Klingner Co.
(ADDRESS) Springfield Mo.

20. FILED Dec. 12 1938 Chas. A. George M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 10 1938

22. I HEREBY CERTIFY, That I attended deceased from 12/6/38 to 12/10/38, I last saw him alive on 12/10/38. Death is said to have occurred on the date stated above, at 6.10p m.
The principal cause of death and related causes of importance were as follows:

Carcinoma of Lung — Date of onset

Other contributory causes of importance:
Influenza

Name of operation None — Date of
What test confirmed diagnosis? X-Ray — Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? — Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Chas. A. George M.D.
(Address) Springfield Mo.

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me R. A. Gavin #1763; W. D. Noblett #4005 ~~or~~ by W. M. Rhodes

Registered Apprentice No. 117, working under my personal supervision.

Signed J. B. K. Lingnell

Licensed Embalmer No. 3358

P. O. Address Springfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.