DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 15 1940

Registration District No. 796

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3038

State File No. 3923

Registrar's No. 13

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.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Marshall (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Robert Foster

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Colored

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nancy

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased April, 18, 1860 (Month) (Day) (Year)

8. AGE: Years 79 | Months 9 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Saline Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Robert Foster
13. Birthplace Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace Don,t Know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nancy Foster

(b) Address Marshall Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 20, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Marshall Mo.

18. (a) Signature of funeral director [illegible] Dalzell

(b) Address Marshall Mo.

19. (a) 1-18-40 (Date received local registrar) (b) Mary Kent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16-1940 year hour 3.30 minute 0 A. M.

21. I hereby certify that I attended the deceased from Jan 4, 19 40, to Jan 16, 19 40, that I last saw h. alive on Jan 16, 19 40, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Parenchymatous Nephritis (Chronic)	1 wk
Due to	
Due to	
Other conditions Sematia Anasica. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

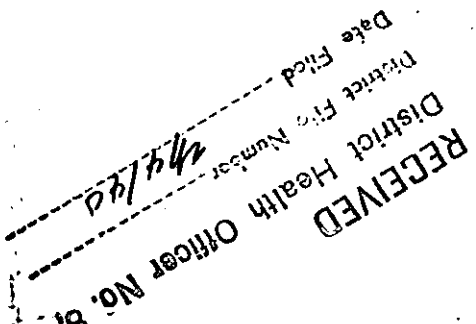
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. H. Nebhut (M. D. or other)

Address Marshall, Mo. Date signed 1-18-40

(Licensed Embalmer's Statement on Reverse Side)



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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Herman Salzer

Licensed Embalmer No. 1534

P. O. Address Slaton Texas

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.