

FILED JAN 20 1945

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH: **BOONE**

(a) County **BOONE**

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

(c) Name of hospital or institution: **Z 210 ST JOSEPH ST**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **XX** (Specify whether)

In this community **30 YEARS**  
years, months or days

3. (a) PRINT FULL NAME **SAMUEL DAVID FOSTER**

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **NB**

4. Sex **MALE**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Virginia FOSTER**

6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **July 31 1860**  
(Month) (Day) (Year)

8. AGE: Years **84** Months **4** Days **8** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Calhoun Co. Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **20 Yr Geology Bldg M.U.**

MOTHER FATHER { 12. Name **John Foster**

13. Birthplace **Illinois**  
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Capps**

15. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Virginia Foster**

(b) Address **210 St Joseph St**

17. (a) **Burial** (b) Date thereof **Dec 13-44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bowling Green Mo**

18. (a) Signature of funeral director **R. O. Willett**

(b) Address **Columbia Mo**

19. (a) **12-11-44** (b) **E. Anna Barber**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**

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

(d) Street No. **210 St Joseph**  
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country **XX**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **9th**  
year **1944** hour **5** minute **P** M.

21. I hereby certify that I attended the deceased **see below** from **Dec 4-5-44** to **Nov 5-1944**

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the day and hour stated above.

Immediate cause of death **Flu** Duration 10 hrs.

Due to **Age 73**

Due to **Delayed for several years at least in bed; but that**

Other conditions **sick**  
(Include pregnancy within 3 months of death)

Major findings: **None**

Of operations \_\_\_\_\_

Of autopsy **None**

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? \_\_\_\_\_

While at work? **No** (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature **W. A. Dyson** (M. D. or other) \_\_\_\_\_

Address **Columbia Mo** Date signed **12-11-44**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 97

District File Number .....

Date Filed 1-19-45

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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 J. O'Beery.....

Licensed Embalmer No. 3183.....

P. O. Address Columbia.....

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, fact should be so stated above.