

No. 2  
-12-45  
-17-39  
X47070

FILED MAY 21 1947

6076

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 192 days  
(Specify whether life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 6535 Curtis  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William A. FOSTER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 year 1947 hour 12 minute 50 A M.

21. I hereby certify that I attended the deceased from 10-30-1945 to 5-10-1947.  
that I last saw him alive on 1947-9- and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race wh

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

6. (b) Name of husband or wife Ester Garcia

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

7. Birth date of deceased: 10 22 1898  
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis

Due to 136

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration 8 years

8. AGE: Years 48 Months 6 Days 28

If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: St. Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation Secretary

11. Industry or business \_\_\_\_\_

12. Name William Foster

13. Birthplace New Orleans (City, town, or county) La (State or foreign country)

14. Maiden name Ester Garcia

15. Birthplace San Juan (City, town, or county) P.R. (State or foreign country)

16. (a) Informant Robert Wood Hospital Records

(b) Address \_\_\_\_\_

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-13-1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Gardens

18. (a) Signature of funeral director Geo. L. Plutschke

(b) Address 5966-68 Easton Avenue

19. (a) 5-14-47 (Date received local registrar)

(b) Casey A. Sharpton (Registrar's signature)

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

(c) 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? \_\_\_\_\_ (Specify type of place)

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

23. Signature Chas. P. Verbitski (M. D. or other)

Address Wentz Hospital Date signed 5-10-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 Ray E Campbell

Licensed Embalmer No. 3881

P. O. Address St Louis, 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, fact should be so stated above.**