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

Do not use this space.

14736

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. .....

City St. Louis Mo (No. City Hospital #2 St. 4140 Ward)

2. FULL NAME Willie Foster

(a) Residence. No. 2715 (A) Sheridan 21 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	Col.	Married.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
abt	33	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foundry-Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

39

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

2

PARENTS

10. NAME OF FATHER Stewart Foster

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss

12. MAIDEN NAME OF MOTHER Susie Collins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Miss

14. INFORMANT A. Gertrude Creath
(Address) City Hosp #2

15. FILED ..... 19 25 1930 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18- 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-18-, 1930, to 4-18-, 1930 that I last saw him alive on 4-18-, 1930, and that death occurred, on the date stated above, at 3:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Pneumonic Phthisis

23A

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (SECONDARY) 31

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH —

0 DID AN OPERATION PRECEDE DEATH NO DATE OF —

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) A. E. Hale, M. D.

4/21/, 1930 (Address) City Hospital #2

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Washington Park	4/26 1930
20. UNDERTAKER	ADDRESS
Manuel Undt Co	4054 Finney

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.