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

Do not use this space.

16487

1. PLACE OF DEATH

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

Township ..... Primary Registration District No. 1003 Registered No. 5008

City St. Louis (No. 2129 Oregon av St. ..... Ward)

2. FULL NAME Charles W. Foster

(a) Residence. No. 2129 Oregon av St., 23 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 60 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	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Foster Hicks

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jany 2, 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tinner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Terminal Ry Assn.

9. BIRTHPLACE (CITY OR TOWN) Georgetown
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Unknown Foster
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown Meaker
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown.

14. INFORMANT M. H. Foster
(Address) 2129 Oregon av

15. FILED 27 1931 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 24 1931

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1931, to April 24, 1931 that I last saw her alive on April 24, 1931, and that death occurred, on the date stated above, at 4.30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia Left Side
10 d
16 d
..... (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at place of Death
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) John C Frame, M. D.
, 19 (Address) 4518 Washington av

*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
Park Lawn Cemetery	Ap. 27 1931
20. UNDERTAKER Leo. E. Cobb	ADDRESS 2115 California

A. E. 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.