DIST. No. N.R.

CERTIFICATE OF DEATH

XVIII CLASS No. 175

DISTRICT OF COLUMBIA

No. OF RECORD 3[illegible]

FULL INSTRUCTIONS FOR THE GUIDANCE OF THOSE USING THIS BLANK AND SPACE FOR REMARKS MAY BE FOUND ON THE OTHER SIDE

1. PLACE OF DEATH:

No. .... Street, ... Section.

Name of Hospital Casualty Hospital Duration of residence therein ....

2. FULL NAME Edward Foster

(a) Residence, No. 1920 N. Nelson St. (Usual place of abode) Street Cherrydale, Va (If nonresident, give city or town and State)

Length of residence in D. of C., ... 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

6A. If married, widowed, or divorced, HUSBAND of (or) WIFE of Callie Foster

6. DATE OF BIRTH (month, day, and year) ....

7. AGE: Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
49			

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

9. BIRTHPLACE (city or town) Illinois
(State or country) ....

PARENTS
10. NAME OF FATHER (in full) ....
11. BIRTHPLACE OF FATHER: City or town .... State or country ....
12. MAIDEN NAME OF MOTHER (in full) ....
13. BIRTHPLACE OF MOTHER: City or town .... State or country ....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) 1-15-, 1937

17. I HEREBY CERTIFY, that I attended deceased from ...., 19...., to ...., 19....

that I last saw h.... alive on ...., 19....

and that death occurred, on the date stated above, at .... m.
The CAUSE OF DEATH* was as follows:
Fractured skull
Injured in auto accident
near Beltsville [illegible] Jan 7 1937

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

CONTRIBUTORY (SECONDARY) [illegible]

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

18. Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of operation ....

Was there an autopsy? None

What laboratory test confirmed diagnosis? ....

(Signed) [illegible signature], M. D.

(Address) Coroner

*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. (See reverse side for additional space.)

19. [illegible]