CERTIFICATE OF DEATH

5133

STATE OF ALABAMA—BUREAU OF VITAL STATISTICS
STATE BOARD OF HEALTH

01

File No. for State Registrar Only. 9150

1 PLACE OF DEATH
County MONTGOMERY, ALA. Reg. District or Beat No. 51-1001 Certificate No.
Town or City MONTGOMERY, ALA. Street or R. F. D. Fresh Air Camp Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2 FULL NAME Eddy Lee Foster

(a) Residence, No. Street or R. F. D. Ward
(Usual place of abode) (If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

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

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS
10 NAME OF FATHER E. L. Foster
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.
12 MAIDEN NAME OF MOTHER Emma Shepherd
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Fresh Air Camp City
(Address)

15 Filed 3-1, 1929 J. J. Bowman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to March 1, 1929, that I last saw h[illegible] alive on Feb-28, 1929, and that death occurred, on the date stated above, at 9: p. m.

The CAUSE OF DEATH* was as follows:
Chronic Pulmonary Tuberculosis
31
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Intestinal Fistula
(duration) yrs. 10 mos. ds.

18 Where was disease contracted or did accident occur?

Was an operation performed? Date of
For what disease or injury?
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Cobbs, M. D.
19 (Address)

19 PLACE OF BURIAL, CREMATION, or REMOVAL Oakwood Cemetery
DATE OF BURIAL 192
20 UNDERTAKER THE LEAK CO.
ADDRESS

*State the disease causing death; see other side for further instructions.