

**AUG 11 1939 791**  
**1008**

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution: St. John's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether years, months or days)

In this community Since Birth

3. (a) PRINT FULL NAME James Terriel Fortner 135

8. (b) If veteran, name was None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive None years

7. Birth date of deceased: January 11, 1934  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

5 6 13 hr. min.

9. Birthplace Cardwell Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation None

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

MOTHER FATHER { 12. Name Oral T. Fortner

13. Birthplace Texas  
(City, town, or county) (State or foreign country)

14. Maiden name Javel Carlile

15. Birthplace Ark.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Oral T. Fortner

(b) Address 4524 Manchester Ave.

17. (a) Shipper (b) Date thereof July 25-39  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Batesville Ark.

18. (a) Signature of funeral director Math. Hermann & Son

(b) Address 2161 East Fair Ave.

19. (a) 111 25 1070 (b) J.P. Burkett  
(Date of local funeral) (Funeral Director's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

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

(d) Street No. 4524 Manchester Ave.  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th  
year 1939 hour 12:56 PM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July 16  
1939 to July 24 1939  
that I last saw him alive on July 24 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis meningitis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

Duration 20 days

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

(a) 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 J.P. Burkett (M. D. or other) \_\_\_\_\_  
Address St. Louis Mo Date signed \_\_\_\_\_

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

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.

1-1 X1931

**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 *William H. Buckhof*  
Licensed Embalmer No. *2110 0*  
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, above space should be left blank.**