

Registration District No. 421910 1149 Primary Registration District No. 5691 Registrar's No. _____

60

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

1. PLACE OF DEATH:

(a) County McDONALD
(b) City or town RURAL CYCLONE TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County McDonal
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME MARSHALL FORBES 67

8. (b) If veteran, name war _____ (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased FEB 1st 1935
(Month) (Day) (Year)

8. AGE: Years 5 Months 1 Days 9 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Carl Forbes

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

14. Maiden name Stella Carter

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

16. (a) Informant Carl Forbes
(b) Address Stella Mrs Rt # 2

17. (a) Burial (b) Date thereof 3-11-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quincy Cemetery
(d) Signature of funeral director Charles Williams
(e) Address Goodman Mo
(f) Date received local registrar 3-10-40 (g) Charles Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10th
year 1940 hour 7 minute 0 A M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cause of death unknown they had no doctor
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 2nd

Major findings: Of operations _____
Of autopsy _____

Duration
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 Joe L. Merrill (M. D. or other) MD
Address Merrill Mo Date signed 3/10/40

RECEIVED

District Health Officer No. 6,

District File Number 340-875

Date Filed MAR 15 1940

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.....

Licensed Embalmer No.....

P. O. Address.....

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.