

S. No. 2
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-5-17-39
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FILED APR 15 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9429
Registrar's No. 2912

Registration District No. 791 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County St. Louis
(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. Lukes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Palmer Forrest
(b) If veteran, name war No. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 9 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
26 4 18 hr. min.

9. Birthplace Ozark Co., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business
12. Name Harvey Forrest
13. Birthplace Ozark Co., Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Della Chian
15. Birthplace Ozark Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Harvey Forrest
(b) Address Parten, Mo.

17. (a) Removal (b) Date thereof 3-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Parten, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) MAR 28 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town Parten NR
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1940 hour 9 minute 00 A.M.

21. I hereby certify that I attended the deceased from March 18, 1940, to March 27, 1940;
that I last saw him alive on March 27, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Brain (Malignant)

Due to 50
Due to 50
Other conditions Terminal pneumonia
(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy No

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 A. M. Kleins (M. D. or other)
Address 4952 Maryland Date signed _____

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

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

Ernest W. Wilkinson

Licensed Embalmer No.

3575

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.