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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24095

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2705

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

1. PLACE OF DEATH:

(a) County: Jackson,

(b) City or town: Kansas City, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2909 Holmes St., (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: no. (Specify whether years, months or days)

In this community: Unknown.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri. (b) County: Jackson,

(c) City or town: Kansas City, (If outside city or town limits, write "RURAL")

(d) Street No.: 2909 Holmes St., (If rural, give location)

(e) If foreign born, how long in U. S. A.? No. years.

3. (a) PRINT FULL NAME: William C. Forsee, 6270

3. (b) If veteran, name war: No.

3. (c) Social Security No.: No.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Mattie L. Forsee,

6. (c) Age of husband or wife if alive: 80 years

7. Birth date of deceased: September (Month) 29 (Day) 1857 (Year)

8. AGE: Years 82 Months 9 Days 6 If less than one day ____ hr. ____ min.

9. Birthplace: Kentucky, (City, town, or county) / (State or foreign country)

10. Usual occupation: Retired Lawyer,

11. Industry or business: x

FATHER 12. Name: Samuel S. Forsee,

FATHER 13. Birthplace: (City, town, or county) Kentucky, (State or foreign country)

MOTHER 14. Maiden name: Hulda DeHoney,

MOTHER 15. Birthplace: (City, town, or county) Kentucky, (State or foreign country)

16. (a) Informant: George H. Forsee,

(b) Address: 2906 Paseo, K. C., Mo.

17. (a) Burial, (Burial, cremation, or removal) (b) Date thereof: 7-6-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Forest Hill Cemetery,

18. (a) Signature of funeral director: Stine & McClure,

(b) Address: 3235 Gillham Plaza, K. C., Mo.

19. (a) July 6, 1940 (Date received local registrar) (b) M. M. Crane (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4th, year 1940 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 15 - 40, 19__, to July 4, 1940; that I last saw him alive on May 30, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: 51

Due to: Carcinomatosis

Due to: the bladder

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: Diagnosis Confirmed by Biopsy of tumor

Of autopsy: by operating Cystoscope

Duration

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Clarence K. Grant (M. D. or other)

Address: 505 Professional Bldg. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

Dr. C. K. Smith,
Professional Bldg.,
Vi 4420

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 J. A. Yates

Licensed Embalmer No. 3992

P. O. Address K C Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.