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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31215

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3778

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: Trinity Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)
In this community 35 Years

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. 4436 Troost Avenue (If rural, give location)
(e) If foreign born, how long in U. S. A.? ------- years.

3. (a) PRINT FULL NAME Doctor Samuel Grover Fore
3. (b) If veteran, name war World War
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mrs. Mabel Fore
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased December (Month) 4 (Day) 1885 (Year)

8. AGE: Years 54 Months 9 Days 24 If less than one day ____ hr. ____ min.

9. Birthplace Linneus (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Dentist
11. Industry or business Chambers Building
FATHER
12. Name Peter Fore
13. Birthplace (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Elizabeth Brown
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mrs Mabel Fore
(b) Address 4436 Troost
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery
18. (a) Signature of funeral director O. M. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd.
19. (a) 9-30-40 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28th year 1940 hour 9 minute 15 A. M.
21. I hereby certify that I attended the deceased from July 15th, 1940 to September 28, 1940; that I last saw him alive on September 28, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
1. Coronary Thrombosis
2. Sclerotic Myocarditis
Due to 3. Hypertension 9 yr
4. Cardiac Hypertrophy
Due to 5. Recent infarcts spleen Kidney and Lungs
Other conditions 6. Cerebral Edema
(Include pregnancy within 3 months of death)
7. Old Ventricular Aneurism
Major findings:
Of operations
Of autopsy Yes

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 Wm K Trimble (M. D. or other)
Address Trinity Hospital Date signed 9/28/1940

(Licensed Embalmer's Statement on Reverse Side)

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 Kenneth P. Lipp

Licensed Embalmer No. 4128

P. O. Address 1309 Brush Creek

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

If this body is not embalmed, fact should be so stated above.