

FILED AUG 11 1943

Registration District No.

Primary Registration District No. 3200

Registrar's No. 192

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: Ellis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

(c) City or town Brushers Mo
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME GEORGE EDWARD FORQUER

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

(b) Name of husband or wife J. Forquer 6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased 6 15 1870
(Month) (Day) (Year)

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

73 1 4 hr. min.

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

10. Usual occupation Insurance

11. Industry or business

12. Name Charles Forquer

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

14. Maiden name Argeline Fort

15. Birthplace Illinois (City, town, or county) (State or foreign country) 1

16. (a) Informant Murita Shahan

(b) Address Brushers Mo

17. (a) Burial (b) Date thereof 7-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brushers Cem

18. (a) Signature of funeral director Summers Powell

(b) Address 115 W Jefferson

19. (a) 7/21/43 (b) A. J. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 43 hour 10 minute 25 AM

21. I hereby certify that I attended the deceased from 1-1-43 to 7-17-43 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage of the left hemisphere

Due to and sequelae of 16 mos

Due to 46

Other conditions (include pregnancy within 3 months of death) 46

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 R R Lewis (M. D. or other) Kirkville Mo

Address Kirkville Mo Date signed 7-20-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number... 8-43-1276

Date Filed... AUG 10 1943

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... *W.C. Summer*

Licensed Embalmer No. *2159*

P. O. Address... *Wicksville Md*

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, fact should be so stated above.