

S. No. 2
M-8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18708

State File No. _____
Registrar's No. **4397**

FILED JUN 19 1945
318

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **12 DAYS** (Specify whether)
In this community **12 DAYS** (Specify whether)
years, months or days

3. (a) PRINT FULL NAME EDWARD G. FORSHEE
3. (b) If veteran, name war **No**
3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Daisy**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **Aug 16 1877**
(Month) (Day) (Year)

8. AGE: Years **67** Months **9** Days **18**
If less than one day hr. _____ min. _____

9. Birthplace **AVA Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Telegrapher**

11. Industry or business **Railroad**

12. Name **Winfield Scott Forshoe**

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

14. Maiden name **Murden**

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

16. (a) Informant **Mrs Dorothy Bullock**

(b) Address **4511 Parkview Place**

17. (a) **Removal** (b) Date thereof **6-4-1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Murphysboro Ill**

18. (a) Signature of funeral director **Ray Crawshaw**

(b) Address **Murphysboro Ill**

19. (a) **JUN 6 1945** (Date received local registrar)
J. F. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Jackson**
(c) City or town **Murphysboro**
(If outside city or town limits, write "RURAL")
(d) Street No. **2030 Jackson** (If rural, give location) **NR**
(e) Citizen of foreign country? **2** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** Day **6** ~~3~~
year **1945** hour **4** minute **55** P.M.
21. I hereby certify that I attended the deceased from **5/23**
19**45** to **6/4** 19**45**
that I last saw him alive on **6/4/45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure**
Due to **Coronary Throcal infarct**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **94**

Major findings:
Of operations _____
Of autopsy _____

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 **J. Schlenker** (M. D. or other) _____
Address **110 Pac Hosp Bldg** Date signed **6/4/45**

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.....

John Ketter

Licensed Embalmer No. 3880

P. O. Address St. Louis Mo

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.