

FILED JUL 18 1945

State File No.

Registration District No. 169

Primary Registration District No. 4261

Registrar's No. 263

1. PLACE OF DEATH:

(a) County Knox
(b) City or town Hurdland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 65 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Knox
(c) City or town Hurdland, 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 Sarah Jane Forrester

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

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Wm. T. Forrester 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased "April - 15 - 1867"
(Month) (Day) (Year)

8. AGE: Years 78 Months 0 Days 16
If less than one day hr. _____ min. _____

9. Birthplace Owen Co. Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER
12. Name Daniel Fiscus
13. Birthplace uk Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Rebeca Conder
15. Birthplace uk Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Wm T Forrester
(b) Address Hurdland, Mo.

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greensburg Missouri

18. (c) Signature of funeral director Keith Hudson

(b) Address Edina, Mo.

19. (a) 5-8-45 (b) Nelle Northcutt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 1st
year 1945 hour 6:30 min. 50 P. M.

21. I hereby certify that I attended the deceased from Apr 29
1945 to May 1 1945;

that I last saw h. _____ alive on _____, 19 _____
and that death occurred on the day and hour stated above.

Immediate cause of death Cerebral Hem- atoxia Duration _____

Due to stroke of rd arteri- al sclerosis

Due to _____

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

Major findings:
Of operations _____
Of autopsy _____

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?

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature Tom W. Kasper (M. D. or other) _____
Address Hurdland Date signed May 4/45

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

52
00

RECEIVED

District Health Officer No. 10

District File Number 7-45-1197

Date Filed JUL 17 1945

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 *Keith Hudson*

Licensed Embalmer No. 2413

P. O. Address. *Edina, Missouri*

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.