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DEPARTMENT OF COMMERCE
BUREAU OF VITAL RECORDS
FILED APR 18 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 1

Primary Registration District No. 3.000

Registrar's No. 104

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution: K. C. O. S. Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 hours
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair

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

(d) Street No. 207 East Filmore
(If rural, give location)

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

3. (a) PRINT FULL NAME Jerald Dee Fortney

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased April 7 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
If less than one day 14 hr. 35 min.

9. Birthplace Kirksville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business X

MOTHER FATHER

12. Name Glen Lavean Fortney

13. Birthplace Millard Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Maegwyn Colleen Aysmuth

15. Birthplace Atlanta Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Crawford M. Estelina D.

(b) Address Kirksville, Missouri

17. (a) Cremation (b) Date thereof April 7, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K. C. O. S. Hospital

18. (a) Signature of funeral director Crawford M. Estelina D.

(b) Address Kirksville, Missouri

19. (a) 4-10-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7th
year 1947 hour 11 minute 15 a. m.

21. I hereby certify that I attended the deceased from April 6, 1947
8:40 a.m. 1947 to 11:15 a.m. April 7, 1947
that I last saw him alive on April 7 1947
and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage into medullary space

Duration _____

Due to Embolic Failure of blood vessels

Due to _____

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

Major findings: 161C

Of operations _____

Of autopsy Medullary space hemorrhage

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 Crawford M. Estelina D. (M. D. or other) _____
Address Kirksville, Missouri Date signed April

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

RECEIVED
Public Health Officer No. 10
42671
APR 17 1947

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.....

Licensed Embalmer No.....

P. O. Address.....

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.