

FILED SEP 24 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33214
State File No.
8533
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Nebraska b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fall City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hosp.		d. STREET ADDRESS (If rural, give location) 2015 Lane street	
3. NAME OF DECEASED a. (First) Norman (Type or Print)		b. (Middle) William c. (Last) Forney	
4. DATE OF DEATH (Month) (Day) (Year) Sept 1 1953		5. SEX M	
6. COLOR OR RACE W		7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH May 25, 1875		9. AGE (In years last birthday) 78 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY RR	
11. BIRTHPLACE (State or foreign country) Nebraska,		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Forney		13b. MOTHER'S MAIDEN NAME Margaret Wicks	
14. NAME OF HUSBAND OR WIFE Jane Forney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 733-12-4878		17. INFORMANT'S SIGNATURE OR NAME Jane Forney, Fall City, Nebr.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia - RLD abscess ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Acute cholecystitis, post-op. DUE TO (c) Operation for pyloric obstruction II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple small intest. adhesions	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Pyloric obstruction - gastrojejunostomy performed.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 545X		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:20 P.m. , from the causes and on the date stated above.	
23a. SIGNATURE L. F. Winkler (Degree or title) M.D.		23b. ADDRESS Missouri Pacific Hosp.	
23c. DATE SIGNED 2 Sept '53		24a. BURLIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 8-2-53		24c. NAME OF CEMETERY OR CREMATORY Fall City, Nebraska	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Dorr-Phillpott, Fall C., Nebr.	
DATE REC'D BY LOCAL REG. SEP 2 1953		REGISTRAR'S SIGNATURE Carl Smith MO	

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Ronald C. Yahrke

Licensed Embalmer No. 2917

P. O. Address St Louis

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.