

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3849**
Registrar's No. **15**

FILED MAR 1 1955.

BIRTH NO. _____ REG. DIST. NO. **11** PRIMARY REG. DIST. NO. **4024**

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

| | | | |
|--|--|---|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Barry | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Barry | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cassville | | c. LENGTH OF STAY (in this place) 3 1/2 Hours | c. CITY OR TOWN Wheaton |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Cassville Community Hospital | | e. STREET ADDRESS (If rural, give location) 1 1/2 Mile South of Wheaton | |

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|-------------------------------------|-------------------------|-------------------------|-------------------------|---------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Elige | b. (Middle) "L". | c. (Last) Forgey | 4. DATE OF DEATH (Month) (Day) (Year) |
| | | | | Feb. 11, 1955 |

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|--------------------|-------------------------------|---|--------------------------------------|---|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov. 7, 1883 | 9. AGE (In years last birthday) 71 |
|--------------------|-------------------------------|---|--------------------------------------|---|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | 11. BIRTHPLACE (City and State or Foreign Country) Benton County, Arkansas | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|---|---|---|

| | | |
|--|---|---|
| 13a. FATHER'S NAME James Forgey | 13b. MOTHER'S MAIDEN NAME Nancy Roller | 14. NAME OF HUSBAND OR WIFE Winnie Bowman Forgey |
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|---|--|---|--------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None | 17. INFORMANT'S SIGNATURE OR NAME Good sign Seligman | ADDRESS 710 |
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| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure | | |
| | ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lobar pneumonia | | | |

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|------------------------|--|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 490X | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 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) |
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| | | |
|---|--|----------------------------|
| 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? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from **1/6**, 19**55**, to **2/11**, 19**55**, that I last saw the deceased alive on **2/11**, 19**55**, and that death occurred at **4:05P** m., from the causes and on the date stated above.

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|--|---------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) Kandal G. Ochs, M.D. | 23b. ADDRESS Wheaton Mo. | 23c. DATE SIGNED 2/13/55 |
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|--|----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 2/11/1955 | 24c. NAME OF CEMETERY OR CREMATORY Roller Cemetery | 24d. LOCATION (City, town, or county) (State) Gateway, Arkansas |
|--|----------------------------|---|--|

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|---|--|--|-----------------------------------|
| DATE REC'D BY LOCAL REG. 2-21-55 | REGISTRAR'S SIGNATURE Mary McDonald | 25. FUNERAL DIRECTOR'S SIGNATURE William J. Burns | ADDRESS Burns Funeral Home |
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(Licensed Embalmer's Statement on Reverse Side) **Ch. Lic. # 550.**

BARRY COUNTY HEALTH UNIT
CASSVILLE, MO.

NO. 255-210

DATE REC. 2-26-55

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.....
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.