

FILED JUL 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18378**

BIRTH NO. _____ REG. DIST. NO. **132** PRIMARY REG. DIST. NO. **3021** Registrar's No. **88**

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

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Grundy b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Trenton c. LENGTH OF STAY (In this place) 28 days d. FULL NAME OF (If in hospital, or institution, give street, town, or location) HOSPITAL OR INSTITUTION Susan's Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Livingston c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wheeling d. STREET ADDRESS (If rural, give location) No street address | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Milton b. (Middle) Fleetwood c. (Last) Forbis | | 4. DATE OF DEATH (Month) (Day) (Year) June 26, 1955 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Sept. 28, 1870 |
| 9. AGE (In years last birthday) 84 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | | 11. BIRTHPLACE (City and State or Foreign Country) New Cambria, Mo. 12. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Own farm. | |
| 13a. FATHER'S NAME Milton Forbis | | 13b. MOTHER'S MAIDEN NAME Sarah E. Lovern | |
| 14. NAME OF HUSBAND OR WIFE Viola (deceased) | | 17. INFORMANT'S SIGNATURE OR NAME Walter Forbis, Wheeling, Mo. | |
| 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. 540-32-3552 | |
| 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diphtheria Mell. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 260X DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? | | | |
| 22. I hereby certify that I attended the deceased from <u>June 25, 1955</u>, to <u>June 26, 1955</u>, that I last saw the deceased alive on <u>June 26, 1955</u>, and that death occurred at <u>11 A.m.</u>, from the causes and on the date stated above. | | | |
| 23a. SIGNATURE J. A. Waffly, M.D. | | 23b. ADDRESS Prentiss, Mo. | |
| 23c. DATE SIGNED June 30, 1955 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE June 28, 1955 | |
| 24c. NAME OF CEMETERY OR CREMATORY Anderson cemetery | | 24d. LOCATION (City, town, or county) (State) Livingston Co., Mo. | |
| DATE REC'D BY LOCAL REG. 6-28-55 | | REGISTRAR'S SIGNATURE J. Irene Jarvis | |
| | | 25. FUNERAL DIRECTOR'S SIGNATURE Donald Jordan - Chillicothe, Mo. | |

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 Richard W. Randall

Licensed Embalmer No. 4866

P. O. Address: Chillicothe, 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.