No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1956

State File No. 31268

BIRTH NO. _____ REG. DIST. NO. 176 PRIMARY REG. DIST. NO. 5652 Registrar's No. 20

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halltown
c. LENGTH OF STAY (in this place): Native
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence Ozark

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Lawrence
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halltown, Ozark
d. STREET ADDRESS (If rural, give location): 0550

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Theodore
c. (Last): Fortner

4. DATE OF DEATH (Month) (Day) (Year): 8-5-1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-29-1872
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months 6, Days 7 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: L
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Pleas Fortner
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF ~~HUSBAND OR~~ WIFE: Nellie Fortner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Ross Fortner — ADDRESS: Halltown Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of throat and glands

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 1998
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1, 1955, *to* 7-5, 1956, *that I last saw the deceased alive on* 7-6, 1956, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. S. Burney M.D.
23b. ADDRESS: Miller Mo
23c. DATE SIGNED: 7-7-56

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-7-1956
24c. NAME OF CEMETERY ~~OR CREMATORY~~: Johns Chapel
24d. LOCATION (City, town, or county) (State): S. of Ash Grove Mo.

DATE REC'D BY LOCAL REG.: 7-5-56
REGISTRAR'S SIGNATURE: W. S. Burney
25. FUNERAL DIRECTOR'S SIGNATURE: Monnie-Leiman — ADDRESS: Miller Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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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 L. R. Leimon

Licensed Embalmer No. 3297

P. O. Address Miller 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.