

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040634
STATE FILE NUMBER

FILED DEC 1 1958

Registration District No. 179 Primary Registration District No. 5667 Registrar's No. 194

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Lincoln</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lincoln</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bedford</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>0570</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lincoln County Memorial Hosp.</u>		Length of stay in 1b <u>8hr</u>	d. STREET ADDRESS <u>1 1/2 Miles west of Troy Mo.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Simon</u> Last <u>Forbeck</u>			4. DATE OF DEATH Month <u>Nov</u> Day <u>22</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1978</u>		9. AGE (In years last birthday) <u>80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Old Monroe</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Anton Forbeck</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Mueller</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Annie Forbeck</u> Address <u>Troy Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA & SEPTICEMIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>MALNUTRITION, DEHYDRATION 4500H</u>					<u>2 WEEKS</u>
DUE TO (c) <u>ADVANCED ARTERIOSCLEROTIC VASCULAR DIS.</u>					<u>UNK.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>① CANCER URINARY BLADDER ② MULTIPLE DECUBITUS ULCERS</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>JULY, 1956</u> to <u>Nov 22, 1958</u> and last saw him alive on <u>NOV. 21, 1958</u> Death occurred at <u>3:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Paul T. Berry MD.</u> (Degree or title)			22b. ADDRESS <u>Troy, Mo.</u>		22c. DATE SIGNED <u>11/24/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 23, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Lincoln County Mo.</u>
24. FUNERAL DIRECTOR <u>Dr. McLaughlin Troy Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-25-58</u>		26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

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 *D. D. McCoy*
Licensed Embalmer No. *3586*
P. O. Address *Tracy, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.