

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010556

FILED VS. APR 11 1960
Kilinger

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 401 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 31 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 821 E. MONROE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last BESSIE FORBIS			4. DATE OF DEATH Month Day Year APRIL 7 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/2/94	9. AGE (last birthday) 65	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) STONE COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY USA	

13a. FATHER'S NAME WILL CHILDERS		13b. MOTHER'S MAIDEN NAME MARTHA POINTS		14. NAME OF HUSBAND OR WIFE JAMES FORBIS (DEC.)	
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. NO		17. INFORMANT Address MRS. WILMA SCHREIBER, SPRINGFIELD, MO	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Previous myocardial infarction June 1958, Dec. 1959			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 a.m. p.m. Month, Day, Year					

20d. INJURY OCCURRED WHILE AT WORK <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 Springfield, MO	COUNTY GREENE	STATE MO
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21. I attended the deceased from **March 1948**, to **4-7-60** and last saw her/him alive on **4-7-60**
Death occurred at **8 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) A. M. K. Kilinger	22b. ADDRESS M. D. Springfield, MO	22c. DATE SIGNED 4-8-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4/9/60	23c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery DELAWARE CEMETERY	23d. LOCATION (City, town, or county) (State) Springfield, MO. NEAR CLEVER, MO.

24. FUNERAL DIRECTOR H. H. LOHMEYER, SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 4-8-60	26. REGISTRAR'S SIGNATURE Effie B. Millon
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(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION
Funeral Director

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer, No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *R/L McCann*

Licensed Embalmer No. 27

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure 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.