SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-009594
STATE FILE NUMBER

AMENDED

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 31

FILED APR 3 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Aurora — Length of stay in lb: 6 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Aurora Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Barry
c. CITY OR TOWN: Galena — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): R#2 — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Lorraine Middle: Last: Forester
4. DATE OF DEATH: Month: March Day: 25 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1/18/61
9. AGE (last birthday): IF UNDER 1 YEAR Months: 2 Days: 7 IF UNDER 24 HR Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Barry County, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Maynard Forester
13b. MOTHER'S MAIDEN NAME: Bernice Branham
14. NAME OF HUSBAND OR WIFE: --
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: --
17. INFORMANT Address: Mrs Maynard Forester, Galena, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a):
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3-20-61, to 3-25-61 and last saw her/him alive on 3-25-61
Death occurred at 11:15 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. Morrison M.D.
22b. ADDRESS: Aurora Mo
22c. DATE SIGNED: 3-25-1961

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 3/25/61
23c. NAME OF CEMETERY OR CREMATORY: Mars Hill
23d. LOCATION (City, town, or county) (State): Barry County Mo.

24. FUNERAL DIRECTOR ADDRESS: Manlove Funeral Home, Crane, Mo.
25. DATE RECD. BY LOCAL REG.: 3-31-1961
26. REGISTRAR'S SIGNATURE: Minnie McNatt Deputy

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed George H Manlove

Signature of Student Embalmer

Licensed Embalmer No. 3827

P. O. Address Crane 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.