WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Shelby

Township Black Creek

or

Village

or

City (NO. , St.: Ward)

Registration District No. 831 File No. 41635

Primary Registration District No. 6092 Registered No. 33

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Samuel F Forman

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH May (Month) 18 (Day), 1844 (Year)

AGE 69 yrs. 6 mos. 25 ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Shelby Co Mo

PARENTS

NAME OF FATHER Joseph H Forman

BIRTHPLACE OF FATHER (City or town, State or foreign country) Indiana

MAIDEN NAME OF MOTHER Irene Best

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Amanda Forman

(ADDRESS) Shelbyville Mo

Filed Dec 14, 1913, Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

DATE OF DEATH Dec (Month) 13 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from about Dec, 1911, to Dec 13, 1913, that I last saw him alive on Dec 13, 1913, and that death occurred, on the date stated above, at 9/55 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

25

130

(Duration) ..... yrs. about mos. 10 ds.

Contributory (SECONDARY) Tabes Mesenterica

(Duration) about 2 yrs. ..... mos. ..... ds.

(Signed) Wm Carson M. D.

Dec 14, 1913 (Address) Shelbyville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 110 yrs. ..... mos. ..... ds. In the State 69 yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence Shelby Co Mo

PLACE OF BURIAL OR REMOVAL Bethany Cemetery

DATE OF BURIAL Dec 15, 1913

UNDERTAKER J W Thompson & Son

ADDRESS Shelbyville Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health

MISSOURI STATE BOARD
BUREAU OF VITAL ST
CERTIFICATE OF DE

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1_____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DE

DATE OF DEATH

_____
(Month)

I HEREBY CERTIFY, that I atte

_____, 191____, to _____

that I last saw h____ alive on _____

and that death occurred, on the date stated

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths fr
(1) Means of Injury; and (2) whether Accidental, Suicidal, o

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITU
RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yr

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DAT
UNDERTAKER	ADI