

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

Do not use this space.

22414

1. PLACE OF DEATH

County St. Francois
Township Basin
City Basin (No.)

Registration District No. 771
Primary Registration District No. 4462

File No.
Registered No.
St. Ward)

2. FULL NAME

Dadie Dorene Fortner

(a) Residence. No. St. Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan. 10 - 1928

7. AGE

YEARS 1

MONTHS 5

DAYS

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

None

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

St. Francois Co

PARENTS

10. NAME OF FATHER

John Fortner

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iron Co Mo.

12. MAIDEN NAME OF MOTHER

Mary Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Deer Co Mo.

14.

INFORMANT

(Address)

Shirley Fortner
Iron Mountain Mo

15.

FILED

7/11/29

J.W. Gale

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

June 10 19 29.

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 4:30 P. m.

THE CAUSE OF DEATH¹⁰ WAS AS FOLLOWS:

By Drowning, in a spring.

CONTRIBUTORY (SECONDARY)

None

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....

J.P. Hester M.D.
June 10, 1929 (Address) Dalozz Mo.

¹⁰State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Basin, Mo.

6/11 19 29

20. UNDERTAKER

ADDRESS

E. Hill

Basin, Mo.

N. B.—Every item of information shown on this certificate is a part of the legal record of the CAUSE OF DEATH in plain terms, so that it can be read and understood by any person.

100-100000-100000

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Francis Registration District No. 471 File No. _____
 Township _____ Primary Registration District No. 4462 Registered No. _____
 City Disminque No. _____ St. _____ Ward _____

2. FULL NAME

Jadie Poline Fortner
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>S</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
- (b) General nature of industry, business, or establishment in which employed (or employer) _____
- (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14. INFORMANT _____
 (Address)

15. FILE NO. 11. 19. 29 _____
J. W. Gale
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 19 29

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw him _____ since on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

By drowning in a
pool
Accidental
 _____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

_____, 19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

20. UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

REGIS... ALL NO... RECEIVE A FEE FOR C... ICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 CAU... on info... should be stated EXACTLY. PHYSICIANS should state...
 WITH IN plain terms, so that it may be...
 WITH IN plain terms, so that it may be...

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