

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

Do not use this space.

17167

**1. PLACE OF DEATH**

County St. Francois  
Township Liberty  
City Knob Lick, Mo. (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 1115  
Primary Registration District No. 6021

File No. \_\_\_\_\_

Registered No. 6

**2. FULL NAME**

Samuel Forrester  
(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF none

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 12, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
72 3 23

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Labourer  
(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) Missouri

10. NAME OF FATHER James N. Forrester

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Georgia

12. MAIDEN NAME OF MOTHER Emily Bain

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

14. INFORMANT Mrs. Sally Mehl  
(Address) Knob Lick, Mo

15. FILED 5/17, 1930 V. V. A. Byrd REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-5 1930

17. HEREBY CERTIFY, That I attended deceased from March 3, 1928, to May 5, 1930, that I last saw him alive on Apr 10, 1930, and that death occurred, on the date stated above, at 1:50 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis

23A

CONTRIBUTORY (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. Home

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) R. Appbony, M. D.

(Address) Farmington Mo May 6, 1930

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL So. O. Cemetery DATE OF BURIAL 5/7 1930

20. UNDERTAKER Meander Med Co ADDRESS Farmington

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 PERMANENT RECORD

JUN 27 1930

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