

OCT 28 1930

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

29428

Do not use this space.

1. PLACE OF DEATH

County Clinton Registration District No. 204
Township Shoal Primary Registration District No. 5073
City (No. 5-282) St. _____ Ward _____

2. FULL NAME Frank Newton Fore

(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 6, 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>38</u>	<u>4</u>	<u>26</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Farmer
(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 Robert Fore

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

12. MAIDEN NAME OF MOTHER Hannie E. Park

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

14. INFORMANT Mrs Robt Fore
(Address) Cameron Mo

15. FILED 9/2 1930 Dr C. H. Riley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 1, 1930

17. I HEREBY CERTIFY that I attended deceased from Aug. 19 1930 to Sept. 1 1930 that I last saw him alive on Aug. 30 1930 and that death occurred, on the date stated above, at 10:30 A.M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute haemorrhage
myelitis
one
81A (duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) None (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS (Signed) H. J. Longwell M. D.

9/2 1930 (Address) Cameron Mo

*State the DISEASE CAUSING DEATH, with 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 Harlow Cemetery DATE OF BURIAL Sept. 2, 1930

20. UNDERTAKER W. Polard ADDRESS Cameron

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.

