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

Do not use this space. 18501

1. PLACE OF DEATH

County Lafayette — Registration District No. 460 — File No.

Township Dover — Primary Registration District No. 5623 — Registered No. 40

City Lexington MO. (No. ..... St. ..... Ward)

2. FULL NAME Clyde Leroy 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June- 21-1914

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	16	10-	25	

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) Lexington
(STATE OR COUNTRY) Lafayette County MO

PARENTS

10. NAME OF FATHER Charley Fortner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Saline County MO.

12. MAIDEN NAME OF MOTHER Josephine Whitaker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Shelby County MO.

14. INFORMANT Chas Fortner
(Address) Lexington, MO.

15. FILED 5-18, 1931 Bessie P Porter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May-16-1931 19

17. I HEREBY CERTIFY, That I attended deceased from May 13th, 1931, to May 16, 1931 that I last saw him alive on May 16, 1931, and that death occurred, on the date stated above, at 7-30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Broncho pneumonia

(duration) ..... yrs. ..... mos. 34 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) [signature], M. D.

, 19 (Address) Lexington Mo

*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
City Cemetery Higginsville. MO.	5/18/31
20. UNDERTAKER Hoefer Meeuwsbogen	ADDRESS H-ville MO.