50
#1

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.

REC'D APR 11 1939

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

10275
Do not use this space.

1. PLACE OF DEATH
(a) County Calloway 3 1 Registration District No. 104
(b) Township Primary Registration District No. 3008 Registered No. 92
(c) City Fulton (d) Street No. State Hospital #1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. 3 mos. 2 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 623 Samuel Dickanson Forrest
(a) Residence, No. Glasgow Mo. St.
(Usual place of abode, if no street address, write county or city) (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) W
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Cynitha Forrest
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 4-1853
7. AGE 85 YEARS 85 MONTHS 7 DAYS 22 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER
13. NAME Forrest
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER
15. MAIDEN NAME Sally Winn
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Effie Hegwood Omaha Neb
18. BURIAL, CREMATION, OR REMOVAL
PLACE Salisbury DATE 3/27 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Geo B Winkelmeier Salisbury Mo
20. FILED Mar. 27 1939 R. N. Creive Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 26th 1939

22. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1938, to Mar 26th 1939
I last saw h. 1 m alive on Mar 26th 1939. Death is said to have occurred on the date stated above, at 1.15 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Injured by a fall - fractured right hip	Mar 20th 1939
Other contributory causes of importance:	
Hypostatic Pneumonia	1939
Arteriosclerosis	
Senile Psychosis	

1860
18

Name of operation Date of
What test confirmed diagnosis? Xray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury Mar 20th 1939
Where did injury occur? Fulton Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
State Hosp #1
Manner of injury Fall from bed on ward
Nature of injury Intertrochanteric fracture rt femur

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Geo. F. Wood M. D.
(Address) State Hospital #1 Fulton, Mo

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(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

Charles B Winkelsmeyer, or by .....

Registered Apprentice No....., working under my personal supervision.

Signed Chas. B. Winkelsmeyer

Licensed Embalmer No. 3842

P. O. Address Salisbury, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.