

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **15781**
Registrar's No. **52**

Registration District No. **677**

Primary Registration District No. **4403**

1. PLACE OF DEATH

(a) County **Shepherd**
(b) City or town **Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) **2**
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days **6 mo**

8. (a) PRINT FULL NAME **Mary Caroline Fore**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Melvin Fore** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Jan 9 1868**
(Month) (Day) (Year)

8. AGE: Years **72** Months **3** Days **5** If less than one day _____ hr. _____ min.

9. Birthplace **Shepherd Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **W. W. Arthur**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Baggett**
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Melvin Fore**
(b) Address **Rural Mo**

17. (a) **Rural** (b) Date thereof **Apr 17 40**
(Burial, cremation, or other) (Month) (Day) (Year)
(c) Place: burial or cremation **Plot at Rural**

18. (a) Signature of funeral director **Paul Egan**
(b) Address **Rural Mo**

19. (a) **4/17/40** (b) **Joe F. Myers**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Shepherd**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **14** year **1940** hour **5** minute **50 P** M.

21. I hereby certify that I attended the deceased from **March 10th** 1940, to **April 14** 1940; that I last saw her alive on **March 15** 1940 and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation** ?

Due to **Hypertension**
Due to **Arteriosclerosis**

Other conditions **Senile Dementia**
(Include prognosis within 3 months of death)
Chr. Nephritis

Major findings: Of operations _____
Of autopsy **121**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature **Paul Egan** (M. D. or other) **1**
Address **Rural Mo** Date signed **4/17/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

78
2
1

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, or by.....

....., Registered Apprentice No.

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 540 591

Date Filed 5.7.40

Signed S. L. Muel

Licensed Embalmer No. 3394

P. O. Address Rolla 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.