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JAN 25 1941 334

State File No. _____

Registration District No. _____

Primary Registration District No. 5468

Registrar's No. 82

1. PLACE OF DEATH: Harrison
 (a) County Harrison
 (b) City or town Rural Florence Twp
 (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)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community all of life years, months or days _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Harrison
 (c) City or town Rural Florence Twp
 (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.

3. (a) PRINT FULL NAME EMMA FORBES

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month December day 20
 year 1940 hour 8 minute 30 A
 21. I hereby certify that I attended the deceased from Dec 15 1940 to Dec 18 1940
 that I last saw her alive on Dec 18 1940
 and that death occurred on the date and hour stated above.

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

Immediate cause of death Cerebral Hemorrhage
 Duration 2 1/2 hrs

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Frank Forbes Deceased 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 17 1863
 (Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 3 If less than one day _____ hr. _____ min.

Due to _____
 Due to 82
 Other conditions _____
 (Include pregnancy within 3 months of death)

9. Birthplace Sherman Twp Harrison Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

12. Name William Bolan
 13. Birthplace Kentucky
 (City, town, or county) (State or foreign country)
 14. Maiden name Eveline Boyce
 15. Birthplace Ill.
 (City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Bert Woodson
 (b) Address Mt. Moriah Mo

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

17. (a) Burial (b) Date thereof Dec 21 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation Sharon Chapel Centy

(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? 300
 (Specify type of place)
 While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director Joe E. Wheeler

23. Signature G. J. Sellers (M. D. or nurse) _____

(b) Address 12-2340
 (Date received by local registrar) (c) G. J. Sellers
 (Registrar's signature)

Address Mt. Moriah Mo Date signed 12/24/40

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

MOTHER FATHER

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.

Signed..... *Joe E. Wheeler*
Licensed Embalmer No. *3512*
P. O. Address..... *Bethany Mo*

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

If this body is not embalmed, fact should be so stated above.