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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27194

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6986

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Children's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Frank Clay  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Letta Delpha Forshee

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Child

6. (b) Name of husband or wife Child 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 30 1930  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>11</u>	<u>1</u>	<u>28</u>	____ hr. ____ min.

9. Birthplace Frank Clay Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Ervin Forshee

13. Birthplace Frank Clay Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Pebbel Lawson

15. Birthplace Centralia Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Ervin Forshee

(b) Address Frank Clay, Mo.

17. (a) Removal (b) Date thereof 8/29/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frank Clay, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Aug 20 1941 Washington Ave.

19. (a) \_\_\_\_\_ (b) J. W. Buddeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 28  
year 1941 hour 7 minute 10 A.M.

21. I hereby certify that I attended the deceased from 7-23  
1941, to 8-28 1941;  
that I last saw her alive on 8-28 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Staph. septemia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) \_\_\_\_\_

Address [Address] Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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

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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..... *W. Wilkins*.....  
Licensed Embalmer No..... *3575*.....  
P. O. Address.....

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6986

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(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  
years, months or days

3. (a) PRINT FULL NAME

Letta Delpha Forsee

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....  
13. Birthplace..... (City, town, or county) (State or foreign country)  
14. Maiden name.....  
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Mar. 5 1942 (b) J. J. Predeck  
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 8  
year 1941 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....  
that I last saw h..... alive on....., 19.....  
and that death occurred on the day and hour stated above.

Immediate cause of death..... Staph septicemia Duration

Due to Staph. osteomyelitis  
of pelvic bone  
Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

SUPPLEMENTARY 24a

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

23. Signature..... (M. D. or other)  
Address..... Date signed.....

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

5-27/94

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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, fact should be so stated above.**