

S. No. 2
-9.4-41
5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43099

FILED JAN 13 1944

State File No. _____

Registration District No. 217

Primary Registration District No. 3045

Registrar's No. 112

1. PLACE OF DEATH:

(a) County MISSISSIPPI

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

(c) Name of hospital or institution:
302 West Cleveland
(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 MISSISSIPPI

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

(d) Street No. 302 W. CLEVELAND
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JAMES GRINSTEAD FORBEY

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____

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

7. Birth date of deceased MARCH 17 1885
(Month) (Day) (Year)

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

58 8 14 hr. _____ min.

9. Birthplace MISS. CO. (City, town, or county) MD. O (State or foreign country)

10. Usual occupation GENERAL LABORER

11. Industry or business _____

MOTHER FATHER

12. Name MOSES FORBEY

13. Birthplace JACKSON CO. ILL
(City, town, or county) (State or foreign country)

14. Maiden name MARTHA MC CISTIC

15. Birthplace WILKINSON CO. ILL
(City, town, or county) (State or foreign country)

16. (a) Informant BRITT FORBEY

(b) Address CHARLESTON, MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-3-43
(Month) (Day) (Year)

(c) Place: burial or cremation DAK GROVE CEMETERY CHARLESTON MO

18. (a) Signature of funeral director John T. [Signature]

(b) Address Charleston, Mo

19. (a) Jan 1/44 (Date received local registrar) (b) [Signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 1 year 1943 hour 6 minute P.M.

21. I hereby certify that I attended the deceased from JANUARY 1, 1943 to December 1, 1943
that I last saw him alive on November 30, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death CAT DIOL RENAL VAS- CULAR Duration _____

Due to DON'T KNOW

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____

131a

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 C. C. Presnell (M. D. or other) M. D.
Address Charleston, Missouri Date signed 12-4-43

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

67
1
2

1257

RECEIVED

District Health Office No. 2,

District File Number 144-69

Date Filed 1-10-44

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

John F. Munnelle Jr.

Licensed Embalmer No. 3851

P. O. Address Charleston

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.