

FILED OCT 29 1944  
199

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. 4209

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos. 26 days  
(Specify whether years, months or days)

In this community 35 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 2538 Lawn  
(If rural, give location)

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

3. (a) PRINT FULL NAME James Forshay

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Kathern Forshay

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased 7 (Month) 21 (Day) 1871 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>2</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation Structial Iron Worker

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

12. Name Abraham Forshay

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

14. Maiden name Zura Forsnay

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

16. (a) Informant Mrs. Kathern Forshay

(b) Address 2538 Lawn

17. (a) Eutial (Burial, cremation, or removal) (b) Date thereof 10 28 44 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918-920 Brooklyn

19. (a) 10-20-44 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18 year 1944 hour 5 minute 10 P.M.

21. I hereby certify that I attended the deceased from July 23 1944 to Oct. 18 1944; that I last saw him alive on Oct. 18 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration \_\_\_\_\_

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

Due to 94a

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

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

Of autopsy See above

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 EMD

23. Signature A. E. Upsher (M. D. or other) 10-19-44

Address Med. Dir. Gen'l Hosp. Date signed \_\_\_\_\_

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

MOTHER FATHER

361

**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 Theron A. Redman  
Licensed Embalmer No. 2737  
P. O. Address T. C. 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, fact should be so stated above.**