

FILED DEC 11 1944

Registration District No. **138**

Primary Registration District No. **5466**

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

1. PLACE OF DEATH:

(a) County **Greene**  
(b) City or town **Rural - S. Campbell Twp**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Medical Center for Federal Prisoners**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 month, 13 days**  
(Specify whether years, months or days)  
In this community **1 month, 13 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **California** (b) County **Los Angeles**  
(c) City or town **Pomona**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **386 W. 8th Street**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **FORTHOFFER, Peter J.**

3. (b) If veteran, name war **World War I** 3. (c) Social Security No. **UNK.**

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

6. (b) Name of husband or wife **Leora Ferguson Forthoffer** 6. (c) Age of husband or wife if alive **UNK.** years

7. Birth date of deceased **September 1, 1896**  
(Month) (Day) (Year)

8. AGE: Years **48** Months **2** Days **19** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **None**

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

12. Name **John Forthoffer**

13. Birthplace **UNK. Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Martha Landers**

15. Birthplace **UNK. Iowa**  
(City, town, or county) (State or foreign country)

16. (a) Informant **File**

(b) Address **M. C. F. P.**

17. (a) **Removal** (b) Date thereof **Nov. 21, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Los Angeles, California**

18. (a) Signature of funeral director **E. C. Thieme**

(b) Address **Springfield, Mo.**

19. (a) **11-21-44** (b) **W. H. Standley**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **20**  
year **1944** hour **2** minute **30** AM.

21. I hereby certify that I attended the deceased from **October 7, 1944** to **November 20, 1944**; that I last saw him alive on **November 20, 1944** and that death occurred on the date and hour stated above.

Immediate cause of death **Adenocarcinoma of right bronchus** Duration **Approx 6 mos.**

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

Due to **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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

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

Of autopsy **Adenocarcinoma of right bronchus Terminal bronchopneumonia of left lower lung.**

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 **E. W. Marchand** (M. D. or D. V. M.)  
Address **Med. Centr. Federal Prisoners** Date signed **11-21-44**

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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..... *Ered C. Priem* .....

Licensed Embalmer No. *2899* .....

P. O. Address..... *Springfield, 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.

X

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. Dec  
 Registrar's No. 914

Registration District No. 13.8

Primary Registration District No. 5466

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

1. PLACE OF DEATH:  
 (a) County Shelby  
 (b) City or town Rural - Campbell  
(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 Peter J. Fortkaffer  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 1944  
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days \_\_\_\_\_ (Less than one day) min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 Nov Year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death adenocarcinoma of right bronchus  
 (Primary site: - At or near bifurcation of right bronchus.)  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 EW Marshall (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

37763