

FILED SEP 12 1945

Registrar's No. **11212530**

Registration District No. **211**

Primary Registration District No. **57774324**

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

1. PLACE OF DEATH: *Miller*
 (a) County *Miller*
 (b) City or town *Jacksonia*
 (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 *3 years*
 years, months or days)

2. USUAL RESIDENCE OF DECEASED: *Miller*
 (a) State *Mo* (b) County *Miller* 66
 (c) City or town *Jacksonia* 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? *no* (Yes or No) 6
 If yes, name country _____

3. (a) PRINT FULL NAME *GEORGE WASHINGTON FORSTER*

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month *Aug* day *1*
 year *1945* hour *3* minute *0* M.

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

21. I hereby certify that I attended the deceased from *Jan*
 _____, 19*45* to *Aug 1*, 19*45*
 that I last saw him alive on *July 23*, 19*45*
 and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
 _____ alive _____ years
 7. Birth date of deceased *May* *10-1874*
 (Month) (Day) (Year)

Immediate cause of death *Coronary Thrombosis* 1 hr
 Duration

8. AGE: Years *71* Months *2* Days *22* If less than one day
 hr. _____ min. _____

Due to *Arteriosclerotic Coronary Disease* 10 yrs.
 Due to _____

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation *Farmer & Laborer*

Major findings: Of operations _____
 Of autopsy *13/2*

11. Industry or business *Farm - Railroad*

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

12. Name *James Forster*

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

14. Maiden name *Susan Jane Shackelford*

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

16. (a) Informant *James Forster*
 (b) Address *Abria, Mo*

17. (a) *Burial* (b) Date thereof *Aug-7-45*
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director *G. L. Casey*
 (b) Address *Abria, Mo*

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. E. Humphrey* (M. D. or other) *200*
 Address *Jacksonia, Mo* Date signed *8-7-45*

RECEIVED

Miller County Health Dept.

County File Number 45-76

Date Filed 9-10-85

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 Ch Casey

Licensed Embalmer No. 2694

P.O. Address Verona 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.