

## FILED APR 24 1946 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 291Primary Registration District No. 5989Registrar's No. 19

## 1. PLACE OF DEATH:

(a) County Putnam  
 (b) City or town Rural Grant  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Livonia, Mo.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community life  
 years, months or days

3. (a) PRINT FULL NAME David Sellers Forbes

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

4. Sex M ♀ 5. Color or race W  
 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife Julia Forbes  
 6. (c) Age of husband or wife if alive 71 years  
 7. Birth date of deceased Dec. 23 1859  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 2 27 hr. min.

9. Birthplace Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

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

12. Name John W. Forbes  
 13. Birthplace Tenn.  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Martha Speak  
 15. Birthplace Ken.  
 (City, town, or county) (State or foreign country)

16. (a) Informant W. H. Forbes  
 (b) Address Unionville, Mo.  
 17. (a) Burial (b) Date thereof 3-22-46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John Cem.  
 18. (a) Signature of funeral director Husted & Son  
 (b) Address Unionville, Mo.  
 19. (a) 3-24-46 (b) Marshall D. Durbin  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Putnam  
 (c) City or town Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Livonia, Mo. R. F. D.  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20  
 1946 year hour 7 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from March 1  
 1946 to March 19 1946  
 that I last saw him alive on March 19 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Carcinoma of  
Diastole & ulcers  
Bladder

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

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

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

Of autopsy \_\_\_\_\_

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 P. V. Hart (M: D. no)  
 Address Carrollville, Mo. Date signed 3-21

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL  
 SUPPLEMENTARY  
 INFORMATION  
 REQUESTED

RECEIVED

District Health Officer No. \_\_\_\_\_

District File Number 4-46-

Date Filed APR 22 1946

**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 F. O. Husted

Licensed Embalmer No. 2975

P. O. Address Unionville N.C.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

Registration District No. *291*

Primary Registration District No. *5989*

Registrar's No. *198*

1. PLACE OF DEATH:

(a) County *Putnam*  
 (b) City or town *Rural*  
(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 *David S. Fisher*

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 *on*

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

7. Birth date of deceased *Dec 23*  
(Month) (Day) (Year)

8. AGE: Years *87* 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 \_\_\_\_\_

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 \_\_\_\_\_

13. (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 *May* 19*46* year \_\_\_\_\_  
 \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration

Due to *Prastate (1st diagnosed)*

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 *P. West* (M. D. or other) \_\_\_\_\_

Address *Contable* Date signed \_\_\_\_\_

SUPPLEMENTARY

MOTHER FATHER

COVER

14137