

FILED JAN 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39333**

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **335**

10
2
4

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

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Columbia	
c. LENGTH OF STAY (In this place) 30 Years			
d. FULL NAME OF HOSPITAL OR INSTITUTION 301 Westmount		d. STREET ADDRESS (If rural, give location) 301 Westmount	

3. NAME OF DECEASED (Type or Print) a. (First) PENELOPE b. (Middle) FORBES c. (Last) FORBES			4. DATE OF DEATH (Month) (Day) (Year) 12 - 30 - 1948		
---	--	--	---	--	--

5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH 12-26-1857		9. AGE (In years last birthday) (Months) (Days) 91		IF UNDER 1 YEAR Hours Mins.		IF UNDER 2 HRS. Hours Mins.	
----------------------	--	-------------------------------	--	---	--	------------------------------------	--	---	--	----------------------------------	--	----------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Ray County, Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.		
--	--	--	-----------------------------------	--	--	---	--	--	--	--	--

13a. FATHER'S NAME S.H. Hill		13b. MOTHER'S MAIDEN NAME Sarah Ann Kinkade		14. NAME OF HUSBAND OR WIFE James H. Forbes	
-------------------------------------	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Sam B. Shirky, Columbia, Mo.	
--	--	-------------------------------------	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> 836		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) arterio-sclerosis DUE TO (c) 99Q 2. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH Sudden	
--	--	---	--	--	--	---	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
--	--	--	--	---	--

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	
--	--	--	--	---------------------------	--

22. I hereby certify that I attended the deceased from **Dec 23, 1948** to **Dec 30, 1948**, that I last saw the deceased alive on **Dec 23, 1948** and that death occurred at **12:45 m.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Roger Price, M.D.		23b. ADDRESS Columbia		23c. DATE SIGNED 12/31/48	
---	--	------------------------------	--	----------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 1, 1949		24c. NAME OF CEMETERY OR CREMATORY Lavelock Cemetery		24d. LOCATION (City, town, or county) (State) Ray County, Missouri	
---	--	-------------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. 12-31-48		REGISTRAR'S SIGNATURE Mrs. R.E. Palmer		31 31		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Parker Funeral Service, Columbia, Mo.	
--	--	---	--	--------------	--	---	--

RECORDED
District Health Officer No. 9,
District File Number
Date Filed JAN 6 1949

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 _____
_____, Student Embalmer No. _____,
working under my personal supervision.

Student
Student Embalmer

Signed Charles H. Haring

Licensed Embalmer No. 4132

P. O. Address Columbia, 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.