

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8369

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1181</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>1 1/2 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4409 Roanoke Parkway</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Agnes</u>		b. (Middle) <u>K.</u>		c. (Last) <u>Forbes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 14, 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Never</u>		8. DATE OF BIRTH <u>Oct. 19, 1875</u>	
9. AGE (In years last birthday) <u>72 73</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>William Jamison</u>		13b. MOTHER'S MAIDEN NAME <u>Mary O'Sullivan</u>		14. NAME OF HUSBAND OR WIFE <u>Davis W. Forbes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>C. F. Wadnayer</u>		ADDRESS <u>4409 Roanoke Parkway</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardio-vascular Disease</u> DUE TO (c) <u>Auricular fibrillation</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>443X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
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)		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 <u>1 March, 1949</u> , to <u>14 March, 1949</u> , that I last saw the deceased alive on <u>14 March, 1949</u> , and that death occurred at <u>4:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Fred H. Lundgren Jr.</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>411 Alameda Rd.</u>		23c. DATE SIGNED <u>14 March 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-15-49</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Burke, So. Dakota</u>	
DATE REC'D BY LOCAL REG. <u>3-15-49</u>		REGISTRAR'S SIGNATURE <u>M. D. Stine</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE &amp; MCCLURE</u>		ADDRESS <u>Kansas City, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

*May E. Meyer.*

Licensed Embalmer No. *4555*

P. O. Address *Kansas City, 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.