

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29643

No. 300  
10. 48

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

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>96</u>	
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		d. STREET ADDRESS (If rural, give location) <u>829 St Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>829 St Louis</u>				d. STREET ADDRESS (If rural, give location) <u>829 St Louis</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANK</u> b. (Middle) <u>A.</u> c. (Last) <u>FORBES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 49</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>Sept 30, 1850</u>		9. AGE (In years last birthday) <u>98</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>San Francisco Calif.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Anthony FORBES</u>		13b. MOTHER'S MAIDEN NAME <u>Alpha Forbes</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Ethel Jean Christie, Ex. Sp.</u> ADDRESS _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>				Instant	
		ANTECEDENT CAUSES					
		<p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b) <u>Arteriosclerosis</u></p> <p>DUE TO (c) _____</p>					
		II. OTHER SIGNIFICANT CONDITIONS					
		<p>Conditions contributing to the death but not related to the disease or condition causing death.</p>				<u>4201</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>4/27/49</u> , 19 <u>49</u> , to <u>8/28/49</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>49</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>8/30/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		24b. DATE <u>Aug 30/49</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Keokuk, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8/30/49</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hope Funeral Home, Excelsior Springs, Mo.</u>			

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

9-16-49

**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.

Signed \_\_\_\_\_

James A. Moler

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 3296

P. O. Address \_\_\_\_\_

Ex Springs, N.J.

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.