

FILED MAR 5 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7295  
State File No. 34

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 3076 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Vernon</u>	
b. CITY OR TOWN <u>Nevada</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Foster, Mo.</u> 1080	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Nevada City Hospital</u>			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <u>Amelia</u> b. (Middle) <u>Pauline</u> c. (Last) <u>Forkner</u>		<u>2-18-51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 7, 1905</u>
9. AGE (In years last birthday) <u>45</u> Months <u>11</u> Days <u>17</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Hallowell, Maine</u>	
12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Jack Crain</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Red. Forkner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Red. Forkner, Foster</u>		ADDRESS <u>Mo</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>Carcinomatous Adenoma of Pelvis</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Adenocarcinoma of Ovary removed 14 months ago</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>175X</u>	
19a. DATE OF OPERATION <u>Dec 1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma Rt Ovary Dec 1949</u>	
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) (Min.)		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>12-14-49</u> to <u>2-18-51</u> , that I last saw the deceased alive on <u>2-18-51</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Wm Hallowell, M.D.</u>		23b. ADDRESS <u>Nevada Mo</u>	
23c. DATE SIGNED <u>2-18-51</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	
24b. DATE <u>2-21-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>M.E. Free</u>	
24d. LOCATION (City, town, or county) (State) <u>Hallowell, Maine</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edith...</u>	
DATE REC'D BY LOCAL REG. <u>2-23-51</u>		REGISTRAR'S SIGNATURE <u>Anna E. Ferris</u>	
25. FUNERAL DIRECTOR'S ADDRESS <u>Edith...</u>		ADDRESS <u>Nevada, Mo.</u>	

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

*Dr. Hallowell*  
*10820*

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED FEB 26 1957

Dist. File 351-430

Date Filed 3-2-57

MAR 29

SEP 25 1959

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed Marsh E. Echeverria

Licensed Embalmer No. 29656

P. O. Address Nebraska, 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.