

FILED APR 27 1951

STANDARD CERTIFICATE OF DEATH

14065
State File No. 3771
Registrar's No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2059	
c. LENGTH OF STAY (In this place) 6 days		d. STREET ADDRESS (If rural, give location) 5966 OAKHURST PLACE	
d. FULL NAME OF HOSPITAL OR INSTITUTION Parklane Memorial Hosp			

3. NAME OF DECEASED (Type or Print) a. (First) Rosa b. (Middle) c. (Last) Forney		4. DATE OF DEATH (Month) (Day) (Year) April 20, 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 19, 1870
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress maker	11. BIRTHPLACE (State or foreign country) Clarksville Mo.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Price	13b. MOTHER'S MAIDEN NAME Tucker	14. NAME OF HUSBAND OR WIFE Samuel Forney
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Parklane Memorial Hospital	ADDRESS 5966 Oakhurst Place
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days 2 yrs. 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		
	ANTECEDENT CAUSES hemiplegia, hypertension, hypertangiosis		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) myocardial damage	
DUE TO (c) Auricular fibrillation			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? H43X
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22. I hereby certify that I attended the deceased on April 12, 1951, to April 20, 1951, that I last saw the deceased alive on April 20, 1951, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE J. M. Black (Degree or title) M.D.	23b. ADDRESS 700 N. Kingshighway	23c. DATE SIGNED April 21/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE April 23/51	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill, Bondine	24d. LOCATION (City, town, or county) (State) Potosi, Mo. St. Charles, Mo.
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DATE REC'D BY LOCAL REG. APR 23 1951	REGISTRAR'S SIGNATURE J. B. Looster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bull-Campbell Mortuary 425 Lindell St. Mo.
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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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *Rex E. Campbell*

Licensed Embalmer No. *3881*

P. O. Address *St Louis, 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.