

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1278**

FILED FEB 1 1953

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 5551 Registrar's No. 44

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

1. PLACE OF DEATH a. COUNTY HOWELL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN R HOWELL TWP.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Howell Twp.	
c. LENGTH OF STAY (in this place) 19 yrs.		d. STREET ADDRESS (If rural, give location) West Plains, Mo. Lebo Rt.	
d. FULL NAME OF HOSPITAL OR INSTITUTION residence			

3. NAME OF DECEASED (Type or Print) FRANCIS ADELBERT FORBES			4. DATE OF DEATH (Month) (Day) (Year) JAN. 24 1953		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH JUNE 25 1865		9. AGE (In years last birthday) 87		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Watertown, N.Y.	

13a. FATHER'S NAME JOEL FORBES		13b. MOTHER'S MAIDEN NAME SYRENA BARNEY		14. NAME OF HUSBAND OR WIFE Jessie May Larson FORBES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. F.A. FORBES, W. Plains, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Double Lobar Pneumonia		DUPLICATE				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES				
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
		DUE TO (b) _____				
		DUE TO (c) _____				
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			490X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Minute)		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 Jan. 21, 1953, to Jan. 24, 1953, that I last saw the deceased alive on Jan. 24, 1953, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE Dr. Richard A. Smith D.O. (Degree or title)		23b. ADDRESS 913 W. Main, West Plains, Mo.		23c. DATE SIGNED 1-28-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-24-53		24c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.	
24d. LOCATION (City, town, or county) (State) West Plains, Mo.		DATE REC'D BY LOCAL REG. 1-30-53		REGISTRAR'S SIGNATURE Beatrice Cook	
25. FUNERAL DIRECTOR'S SIGNATURE Edal Thomburgh		ADDRESS W. Plains, Mo.			

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, ~~by~~.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Har J. Stouffer*

Licensed Embalmer No. *3408*

P. O. Address *W. Plains, 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.