

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35139**
Registrar's No. **432**

FILED OCT 28 1953
BIRTH NO. **27781** REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007**

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

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Butler, | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY New Madrid | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff, Missouri | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gideon, | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Doctors Hospital | | d. STREET ADDRESS (If rural, give location) | |

| | |
|---|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) Doris b. (Middle) Jean c. (Last) Fortner | 4. DATE OF DEATH (Month) (Day) (Year) 5 20 1953 |
|---|---|

| | | | | | | | |
|----------------------|-------------------------------|---|---------------------------------|--|-------------------------------|--------------------------------|--------------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child | 8. DATE OF BIRTH 5 18 53 | 9. AGE (In years last birthday) 2 | IF UNDER 1 YEAR Days 2 | IF UNDER 24 HRS. Hours | Min. |
|----------------------|-------------------------------|---|---------------------------------|--|-------------------------------|--------------------------------|--------------|

| | | | |
|--|-----------------------------------|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Poplar Bluff, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|-----------------------------------|--|--|

| | | |
|---|---|---|
| 13a. FATHER'S NAME Farris D. Fortner | 13b. MOTHER'S MAIDEN NAME Anna E. French | 14. NAME OF HUSBAND OR WIFE None |
|---|---|---|

| | | | |
|--|-----------------------------------|--|---------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | 16. SOCIAL SECURITY NO. no | 17. INFORMANT'S SIGNATURE OR NAME Farris D. Fortner | ADDRESS Gideon, Missouri |
|--|-----------------------------------|--|---------------------------------|

| | | | |
|---|---|--|----------------------------------|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cardiac failure DUE TO (c) atelectasis (lungs) | | |
| 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"/> |
|------------------------|----------------------------------|--|

| | | |
|--|--|---|
| 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 **5 18 53**, 19___, to **5 20 53**, 19___, that I last saw the deceased alive on **5 20 53**, 19___, and that death occurred at **6:50 Am.**, from the causes and on the date stated above.

| | | |
|--|--|----------------------------------|
| 23a. SIGNATURE [Signature] (Degree or title) O M. D. | 23b. ADDRESS Poplar Bluff, Missouri | 23c. DATE SIGNED 5 21 53- |
|--|--|----------------------------------|

| | | | |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 5-20-53 | 24c. NAME OF CEMETERY OR CREMATORY Stanfield Cemetery | 24d. LOCATION (City, town, or county) (State) Near Clarkton, Mo. |
|---|--------------------------|--|---|

| | | | |
|--|--|---|--------------------------|
| DATE REC'D BY LOCAL REG. 10/21/53 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE [Signature] | ADDRESS [Address] |
|--|--|---|--------------------------|

RECEIVED
OCT 26 1953
BUTLER CO. HEALTH CENTER
FILE No. _____

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 _____
Student Embalmer

Signed *Lloyd Mc Russell*

Licensed Embalmer No. *509-766*

P. O. Address *Figgott Ark*

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.