

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36170

State File No.

BIRTH NO.		REG. DIST. NO. <u>324</u>		PRIMARY REG. DIST. NO. <u>3072</u>		Registrar's No. <u>180</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall, Mo.</u>		c. LENGTH OF STAY (in this place) <u>14 Hrs.</u>		c. CITY OR TOWN <u>Marshall, Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>309 N. Benton</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Orie</u>		b. (Middle) <u>Guy</u>		c. (Last) <u>Foree</u>	
4. DATE OF DEATH		(Month) <u>Oct.</u>		(Day) <u>19</u>		(Year) <u>1954</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug. 6-1879</u>	
9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber-(Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cut Hair</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Green Castle, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Stephen A. Foree</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ashbrook</u>		14. NAME OF HUSBAND OR WIFE <u>Rosie Sanders Foree</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>500-20-2175</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Evelyn Ellis-Kansas City, Kansas</u>			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>240</u>	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Hepatitis</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Chronic Myocarditis 4 yrs.</u>					
		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 <u>1222</u>				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) m.		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>Nov 18 1954</u> , 19 <u>53</u> , to <u>10/19</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Oct 18 1954</u> and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>William M.D.</u> (Degree or title)				23b. ADDRESS <u>Marshall Mo.</u>		23c. DATE SIGNED <u>10/19/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/21/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ridgecrest</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>10-21-54</u>		REGISTRAR'S SIGNATURE <u>Frances J. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lehigh Swanson</u>		ADDRESS <u>Marshall, Mo.</u>	

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *J. Lealie Swanson*

Licensed Embalmer No. *3235*

P. O. Address *M. ...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.