

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011066
STATE FILE NUMBER

FILED APR 11 1958

Registration District No. 290 Primary Registration District No. 4427 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi Co	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Waynesville, MO		c. CITY OR TOWN Charleston, Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Way. Gen. Hosp.		d. STREET ADDRESS (If outside, give location) None.	
3. NAME OF DECEASED (Type or print) First Ora Middle Elizabeth Last Forbey		4. DATE OF DEATH Month March Day 30 Year 1958	
5. SEX Female	6. COLOR OR RACE White.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 23-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (City and state or country) Missouri
13a. FATHER'S NAME Samuel Locker.		13b. MOTHER'S MAIDEN NAME Unknown.	14. NAME OF HUSBAND OR WIFE Arch Forbey
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. None.	17. INFORMANT Address Frank M. Forbey Charleston, Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 26 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			331X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Deafness			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 3.27.58 to 3.30.58 and last saw her alive on 3.30.58 Death occurred at 4:00 P.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. O. Allwert (Degree or title) D.O.		22b. ADDRESS Waynesville, Mo	22c. DATE SIGNED 3-30-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3/30/58	23c. NAME OF CEMETERY OR CREMATORY Oddfellows Cemetery	23d. LOCATION (City, town, or county) (State) Charleston, Mo
24. FUNERAL DIRECTOR Hedges Funeral Home ADDRESS Way, Mo		25. DATE RECD. BY LOCAL REG. 3-30-58	26. REGISTRAR'S SIGNATURE Paula Gray Anderson

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

856. & NHP

JUN 3 1958

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 *Clarence Moss*

Licensed Embalmer No. *4896*

P. O. Address *Waymaville, Va*

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.