

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033444

REGISTRATION DISTRICT NO. 324 Primary Registration District No. 3072a Registrar's No. 149 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Marshall</i>	Length of stay in 1b <i>42 yrs</i>	c. CITY OR TOWN <i>Marshall</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Fitzgibbon</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>325 N. Benton</i>

3. NAME OF DECEASED (Type or print) First Middle Last <i>PETER FLOURNOY FOREE</i>			4. DATE OF DEATH Month Day Year <i>August 17, 1960</i>	
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5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>12-27-1874</i>	9. AGE (last birthday) <i>85</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	11. BIRTHPLACE (City and state or country) <i>Linneus Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>
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13a. FATHER'S NAME <i>Stephen A. Foree</i>	13b. MOTHER'S MAIDEN NAME <i>Mary Edna Ashbrook</i>	14. NAME OF HUSBAND OR WIFE <i>Lucie Foree</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	16. SOCIAL SECURITY NO. <i>709-12-0417</i>	17. INFORMANT Address <i>Mrs Lucie Foree Marshall Mo</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Arteriosclerosis (Generalized)</i>	<i>UNKNOWN</i>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Broncho pneumonia</i>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from *May 1959* to *August 17, 1960* and last saw ^{him} *live on August 17, 1960*
Death occurred at *10:34 P* m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Robert W. Alabach MD</i>	22b. ADDRESS <i>370 S Odell, Marshall, Mo</i>	22c. DATE SIGNED <i>8-18-60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Aug. 21, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ridge Park</i>	23d. LOCATION (City, town, or county) (State) <i>Marshall Mo</i>
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24. FUNERAL DIRECTOR ADDRESS <i>Harry Hershberger Marshall Mo</i>	25. DATE RECD. BY LOCAL REG. <i>8-19-60</i>	26. REGISTRAR'S SIGNATURE <i>Cecil L. Reed</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 8 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harry Hersheyberg

Licensed Embalmer No. 435

P. O. Address Marsha

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.