

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039988

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 340

FILED NOV 27 1961

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Knox</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>	Length of stay in 1b <b>7 mo</b>	c. CITY OR TOWN	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Stickler Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>C</u> Last <u>Foreman</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>1961</u>		
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4 May 1886</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Wayne County, Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>John C Foreman</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Porter</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth E Skinner</b>
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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)	17. INFORMANT Address <b>Mrs. Milton C Foreman Hurdland, Mo</b>
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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) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertension</b>	<b>3 years</b>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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 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
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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 <b>May 6, 1961</b>	COUNTY <b>Hurdland Mo</b>	STATE
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21. I attended the deceased from <b>May 6, 1961</b> to <b>Nov. 18, 1961</b> and last saw <sup>her</sup> him alive on _____ Death occurred at <b>10:30 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>R O Stickler M.D.</b>	22b. ADDRESS <b>107 E. Harrison, Kirksville, Mo.</b>	22c. DATE SIGNED <b>11/20/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>22 Nov 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Centery</b>	23d. LOCATION (City, town, or county) (State) <b>Hurdland Mo</b>
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24. FUNERAL DIRECTOR ADDRESS <b>HUDSON-RIMER FUNERAL HOME Edina, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>11-22-61</b>	26. REGISTRAR'S SIGNATURE <b>Dore W. Pattiff</b>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

JUN 18 1962

Abair

Kirkville

Sticker Hospital

R.O. STICKLER, M.D.

Knox

No.

X

X

C  
X

May 1886 75

M

M

Wayne County, Iowa USA

Partner

Ruth F Skinner

Matilda Porter

C Foreman

487-18-6943 :rs. Milton C Foreman Hurling, 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,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *ROR*

Licensed Embalmer No. 5047

P. O. Address Edina, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.