

MISSOURI DEPARTMENT OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

61-040860

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 73

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LIBERTY TWP.</u>	Length of stay in 1b <u>1 YR.</u>	c. CITY OR TOWN <u>MOUND CITY</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 MI N. OF MOUND CITY</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7 MILES NORTH</u>	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>RICHARD EVERETT FORNEY</u>			4. DATE OF DEATH Month Day Year <u>DEC. 6, 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1916</u>	9. AGE (last birthday) <u>45</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL LABOR</u>		11. BIRTHPLACE (City and state or country) <u>FOREST CITY, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JAMES W. FORNEY</u>		13b. MOTHER'S MAIDEN NAME <u>GEORGIA M. LIPPOLD</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>JAMES W. FORNEY - MOUND CITY, MO.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BULLETS THRU BRAIN (RIFLE BULLET) INSTANT</u> <u>R 1947 TRUCK - LEFT PARIETAL</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (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 checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>SELF-INFLICTED GUN-SHOT - 22 CAL. RFL</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>4:30 - p.m.</u>	Month, Day, Year <u>12-6-61</u>		
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

21. I attended the deceased from _____ to _____ and last saw her alive on NO
Death occurred at ABOUT 4:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>D. H. E. Colahan D.O., Licensed H.L.T.U., Oregon, Mo.</u>	22b. ADDRESS	22c. DATE SIGNED <u>12-8-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-9-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>	23d. LOCATION (City, town or county) (State) <u>MOUND CITY, MO.</u>
24. FUNERAL DIRECTOR <u>JAMES H. CRAWFORD, MOUND CITY, MO.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-8-1961</u>	26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>

DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

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 James H. Bradford
Licensed Embalmer No. 4796
P. O. Address Mound City

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.