

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40624

Do not use this space.

1. PLACE OF DEATH
 (a) County RAY Registration District No. 739
 (b) Township CAMDEN Primary Registration District No. 4441 Registered No. _____
 (c) City FLEMING, MO. (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 29 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ATISON MILTON ORR
 (a) Residence, No. FLEMING, MO. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF KATE OLIVE METCALF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-9-1894

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 45

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) BURKINGTON, IOWA

FATHER 13. NAME John Williamson Orr

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

MOTHER 15. MAIDEN NAME Housia Fleenor

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) Mrs. Adra Johnson Fleming, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE BAVIER, MO DATE 7-26-39

19. FUNERAL DIRECTOR (ADDRESS) Gibson & Son Orrick, Mo.

20. FILED Dec 7 1939 Mamm Middleton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-24-39 1939

22. I HEREBY CERTIFY, That I attended deceased from July 22, 1939, to July 24, 1939. I last saw him alive on July 16, 1939. Death is said to have occurred on the date stated above, at 4:05 pm. The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage -
Recurrent -
131
 Other contributory causes of importance:
Arterio-Sclerosis -
Organic Heart Disease
Chronic Nephritis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify no
 (Signed) Robt. Shertz M. D.
 (Address) Orrick Missouri

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THE OCCUPATIONAL BOARD
FOR THE PROFESSION OF
EMBALMERS

STATEMENT BY LICENSED EMBALMER

I, G. V. Gibson, Licensed Embalmer No. 2299

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.
No. _____ or by EC Gibson, Registered Apprentice No. 151
working under my personal supervision.

Signed [Signature]
Licensed Embalmer No. 2299

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 739
 (b) Township Camden Primary Registration District No. 2974 Registered No. _____
 (c) City _____ Street No. _____ St. _____
 (d) (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Atkinson Milton Orr
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid
(write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-24 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-9-1859

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS 78 MONTHS 5 DAYS 15 IF LESS than 1 day, _____ hrs. or _____ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Dec 7 1939 Frank Middle Local Registrar

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Robert Sheets, M. D.

(Address) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Every item of information should be carefully supplied. AGE should be stated EXACTLY IN PLAIN TERMS, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.

