

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

Do not use this space.

21322

1. PLACE OF DEATH

County Jackson
Township Blue
City Keeds (No. Keeds)

Registration District No. 399
Primary Registration District No. 1002
Ward 14

File No.
Registered No. 2005
St. 2005 (Ward)

2. FULL NAME

(a) Residence. No. Keeds St. 14 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 22 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 56 3 9

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) N.Y.
(STATE OR COUNTRY)

10. NAME OF FATHER Haywood Orrin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) N.Y.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Fellens Cushman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) N.Y.
(STATE OR COUNTRY)

14. INFORMANT Haywood W. Orrin
(Address) 140 Downing St Albany

15. FILED 7/4 1927 M. M. Crowell
REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 1 1927

17. I HEREBY CERTIFY, That I attended deceased from July 1 1927 to July 1 1927 that I last saw him alive on July 1 1927, and that death occurred, on the date stated above, at Keeds m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary tuberculosis

2317 (duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY) 31
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No

0 DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? clinical findings
(Signed) Robert C. Mann M. D.

(Address) 3500 E 3 St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL 7/5 1927

20. UNDERTAKER O. Mast ADDRESS

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.

DEC 29 1943