JUL 22 1930

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

Do not use this space.

15611

1. PLACE OF DEATH
County Clark — Registration District No. 193 — File No.
Township DesMoines — Primary Registration District No. 5270 — Registered No.
City (No. St. Ward)

2. FULL NAME John Orth
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 18 1856.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
73	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Cincinnatti, Ohio

PARENTS
10. NAME OF FATHER Wm. Orth
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER (?) Neideraus
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT Mrs John Orth
(Address) Alexandria, Mo. R.F.D

15. FILED 5 15 1930 H F Kircher REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 13 30. 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to May 10, 1930 that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 6 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dilitation of the Heart
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
Arthritis Rheumatism (duration) 15 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H O Strosnider, M.D
5-15, 1930 (Address) St Francisville

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Moss Ridge (Carthage, Ill
DATE OF BURIAL: 5 15 30

20. UNDERTAKER H.F. Kircher Wayland
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.