

REC'D DEC 5 1934

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

39018
Do not use this space.

1. PLACE OF DEATH

(a) County Wallas Registration District No. 241
 (b) Township McBenton Primary Registration District No. 53-54
 (c) City Buffalo (d) Street No. 4147 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 1196

2. PRINT FULL NAME

(a) Residence, No. 6 Vance Haggard Ormsbee 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 24 - 1917

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 9 29

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Bookkeeper
 9. Industry or business in which work was done, as saw mill, bank, etc. Lumber yard
 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) Copeland, Kan.

FATHER 13. NAME Geo. Ormsbee

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas Co. Mo.

MOTHER 15. MAIDEN NAME Claudine Odell

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Laclede Co. Mo.

17. INFORMANT (ADDRESS) Geo. Ormsbee Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 9-22-34

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L. B. Jones Buffalo Mo.

20. FILED 11/6 1934 Thomas Morrow Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-22-34

22. I HEREBY CERTIFY, That I attended deceased from 9-13 1934, to 9-21 1934

I last saw him alive on Oct 21 1934. Death is said to have occurred on the date stated above, at 5:15 P.M.

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

Typical (reported intubation and removal of stomach)
 Date of onset 9-?

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 _____, 1934

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? no

If so, specify _____

(Signed) C. O. Hammer, M. D.

218 (Address) Buffalo Mo.

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.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF HEALTH OFFICERS

RECEIVED
District Health Officer No. 7
District File Number 7-38-412
Date Filed 11-21-38

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

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.