

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REC'D JUL 12 1939

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

20378
Do not use this space.

1. PLACE OF DEATH

(a) County.....² Registration District No. **791**
 (b) Township..... Primary Registration District No. **1008**
 (c) City **of St. Louis** (d) Street No. **2347 Albion Pl** St. **5222**
 (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

(a) Residence, No. **600 Silva Orr** St. **2347 Albion Place** St. **23**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female	4. COLOR OR RACE white	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) August 8, 1879				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	59	10	--	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk			
	9. Industry or business in which work was done, as saw mill, bank, etc. Tobacco Co.			
	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) Missouri 0				
FATHER	13. NAME William Orr 1			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee 0			
MOTHER	15. MAIDEN NAME Catherine Martin			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri			
17. INFORMANT Mrs. Martha Miller (ADDRESS) 2347 Albion Place				
18. BURIAL CHURCH OR RESERVE in PLAC St. Matthews Cam DATE 6/10/39 19 39				
19. FUNERAL DIRECTOR (NAME) A. W. McLaughlin (ADDRESS) 2301 Lafayette Avenue				
20. FILED JUN 10 1939 J. F. Bredich Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6/8/39** 19**39**

22. I HEREBY CERTIFY, That I attended deceased from **March 26**, 19**39**, to **June 7**, 19**39**
 I last saw her alive on **June 17**, 19**39** Death is said to have occurred on the date stated above, at **12 Noon** m.
 The principal cause of death and related causes of importance were as follows:
Apoptosis
 Other contributory causes of importance:
Cerebral Lesion

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 homicid?..... 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) **John P. Dwyer**, M. D.
 (Address) **1620 S. Jefferson**

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 L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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.