

Registration District No.

399

Primary Registration District No.

1002

Registrar's No.

4396

## 1. PLACE OF DEATH:

(a) County Jackson /  
 (b) City or town Kaw  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Research Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 weeks  
 (Specify whether  
 In this community 27 years  
 years, months or days)

## 8. (a) PRINT

FULL NAME W. Edgar Orndorff 653

## 8. (b) If veteran,

name war None

## 8. (c) Social Security

No. None4. Sex Male5. Color or  
race White6. (a) Single, widowed, married,  
divorced Married6. (b) Name of husband or wife Mrs. Willie Orndorff6. (c) Age of husband or wife if  
alive 54 years7. Birth date of deceased Mar. 8, 1881  
(Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

5888

hr. min.

## 9. Birthplace

(City, town, or county)

Tenn

(State or foreign country)

## 10. Usual occupation

Lawyer /

## 11. Industry or business

MOTHER FATHER { 12. Name Eugene Orndorff /18. Birthplace Ky /  
(City, town, or county) (State or foreign country)14. Maiden name Frances Smith15. Birthplace Ark.  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mrs. Willie Orndorff(b) Address 424 Askew, K.C. Mo.17. (a) Burial (b) Date thereof Nov. 18-39  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Mt Washington Cem.18. (a) Signature of funeral director C.H. Blackman & Son, Inc.(b) Address 2825 Inden. Blvd. K.C. Mo.19. (a) Nov 17, 1939 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 424 Askew  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16  
 year 1939 hour 3:30 minute A M.

21. I hereby certify that I attended the deceased from  
Sept 18 1939, to Nov 16 1939;  
 that I last saw him alive on Nov 15 1939;  
 and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma of pancreas

Duration

6 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Ca of pancreas

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? /

(Specify type of place)  
(e) Means of injury23. Signature Robert Edgami (M. D. or other)Address 820 prof Bldg Date signed

Dr. Robert C. Davis, Prof. Bldg.

**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 H. D. Blackman

Licensed Embalmer No. 3639

P. O. Address R. C. Mo.

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

38632  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township K.C. Primary Registration District No. 1002 Registered No. 4396  
 (c) City K.C. (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 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME W. (M<sup>m</sup>) Edgar Orndorff  
 (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

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

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

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

7. AGE YEARS 58 MONTHS 8 DAYS 8 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 11/17 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 16 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_ to \_\_\_\_\_ 19\_\_

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

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

Date of onset

Other contributory causes of importance:

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 C. Davis M. D.

(Address) 820 Prof Bldg

SUPPLEMENTARY

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.

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

