

21699

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 295

Primary Registration District No. 5412

Registrar's No. 70

JUL 16 1940

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Sullivan, (Rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution travelling.
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Cook

(c) City or town Chicago
(If outside city or town limits, write "RURAL")

(d) Street No. 267 Washington Road,
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Ally Alstyne Orloff, 1st

3. (b) If veteran, name war _____

3. (c) Social Security No. 526-20-2239

4. Sex Female 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Conrad A. Orloff 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Mar. 17 1909
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

31	2	19	hr. min.
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9. Birthplace Winnipeg, Manitoba - Canada.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER { 12. Name Carl Alstyne 7

13. Birthplace Russia Russia. 7
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Russia
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. A. Orloff

(b) Address 267 Washington, Chicago, Ill

17. (a) Removal & (b) Date thereof June 9, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winnipeg, Canada.

18. (a) Signature of funeral director Wm. P. Shaffer

(b) Address Sullivan, Missouri.

19. (a) 6-7-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1940 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Crushed Head, Broken Arm, other injuries abrasions.

Due to Automobile Accident.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations None

Of autopsy None

Underline the cause to which death should be charged statistically

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

(a) Accident, suicide, or homicide (specify) Accident.

(b) Date of occurrence June 6, 1940.

(c) Where did injury occur? 3 Miles East Sullivan,
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway # 66, Bad Curve.

While at work? Travelling (Specify type of place) (State)

Means of injury Automobile

23. Signature Wm. P. Shaffer (Name of Registrar)

Address Sullivan, Mo. Date signed 6/6/40

WHILE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 x 2511

210A-
956

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 Phos. P. Shaffer

Licensed Embalmer No. 2692

P. O. Address Sullivan, Missouri

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.

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State File No. **21699**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **295**

Primary Registration District No. **5412**

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF BIRTH:

(a) County **Franklin**
(b) City or town **Meramec T.P.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Ally Abstype Delaff

(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **31** Months **2** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (City, town, or county) (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **5** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Crushed Head Broken arm Other injuries abrasions**

Due to **automobile accident**

Due to **Collision with Motor Truck side swipe**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:

Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 injury _____

23. Signature **Thos J. Shuffler** (M. D. or other) _____

Address **Sullivan** Date signed _____

SUPPLEMENTAL

Handwritten text, possibly a signature or date, located in the lower-left quadrant of the page.