

No. 2  
13-40  
17-39  
X23189

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40889

State File No. ....

Registration District No. 1399

Primary Registration District No. 1002

Registrar's No. 4566

1. PLACE OF DEATH: Jackson  
 (a) County: Kansas City  
 (b) City or town: Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: K.C. General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
 In this community 28 years 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME: ENOS ORR

3. (b) If veteran, name war: Unknown (c) Social Security No.: unk

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

6. (b) Name of husband or wife: Unknown 6. (c) Age of husband or wife if alive: 27 years

7. Birth date of deceased: June 27 1865 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>5</u>	<u>12</u>	hr. min.

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

10. Usual occupation: none

11. Industry or business: none

12. Name: David Orr

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

14. Maiden name: Rose Jones

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

16. (a) Informant: Records Clerk

(b) Address: 1100 S. Main Street

17. (a) Burial (b) Date thereof: 12-10-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Memorial Park

18. (a) Signature of funeral director: Wm. A. Johnson

(b) Address: City (c) Date: 12/9/41

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

2. USUAL RESIDENCE OF DECEASED:  
 (a) State: Missouri (b) County: Jackson 048  
 (c) City or town: Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No.: 1719 Prospect  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 9th year 1941 hour 4 minute 05 A. M. M.

21. I hereby certify that I attended the deceased from 12-6-41, 1941, to 12-9-41, 1941; that I last saw him alive on 12-9-41, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occlusion  
Pulmonary congestion

Due to: gita

Other conditions: none (Include pregnancy within 3 months of death)

Major findings:  
 Of operations: \_\_\_\_\_  
 Of autopsy: \_\_\_\_\_

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: 0

23. Signature: Dr. R. K. Shora (M. D. or other) Med. Dir. K.C. Gen. Hospital, K.C., Mo. Address: \_\_\_\_\_ Date signed: \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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

*Wm A Johnson*

Licensed Embalmer No. *3089*

P. O. Address *112 mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**