

ED APR 6 1943

State File No. \_\_\_\_\_

Registration District No. 304

Primary Registration District No. 3072

Registrar's No. 66

1. PLACE OF DEATH:

(a) County SALINE

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

(c) Name of hospital or institution:  
NO  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Life years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County SALINE

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

(d) Street No. 468 So English  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lillie Delora ORDWAY

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 16  
year 1943 hour 3 minute 30P.M.

4. Sex FEMALE 5. Color or race White

6. (a) Single, widowed, married, divorced, Wid.

6. (b) Name of husband or wife Hiram Ordway 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 5 1861  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 12 1943 to March 16 1943  
that I last saw her alive on March 16 1943  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>81</u>			_____ hr. _____ min.

Immediate cause of death Fractured Right Tibia + Left Femur Duration 3 days

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

Due to Paralysis of left arm + leg 8 1/2 yrs

Due to Hypertension 12 yrs

10. Usual occupation \_\_\_\_\_

Other conditions Encephalomalacia 6 yrs  
(Include pregnancy within 3 months of death)

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Michael Schreckler

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

14. Maiden name MARY ERNST

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

Major findings: \_\_\_\_\_

Of operations None

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs JACK Bafford

(b) Address MARSHALL Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MARCH 20 43  
(Month) (Day) (Year)

(c) Place: burial or cremation RIDGE PARK

18. (a) Signature of funeral director Don Short

(b) Address MARSHALL

19. (a) 3-19-43 (Date received local registrar) (b) Mo. T. O. Weathercock (Registrar's signature)

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

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

(b) Date of occurrence 3-13-43

(c) Where did injury occur? Home, Marshall, Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall

23. Signature W. J. ... M. D. (M. D. or other) 3/18/43  
Address Marshall, Mo Date signed \_\_\_\_\_

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

RECEIVED

District Health Officer No. 8,

District File Number -----

Filed 4-7-43 -----

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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 Ronald W. Short .....

Licensed Embalmer No. 3757 .....

P. O. Address Marshall 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, fact should be so stated above.