

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 31 1944 18

Primary Registration District No. 1003

Registrar's No. 6157

1. PLACE OF DEATH:

(a) County St. Louis, Mo

(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 9 days
(Specify whether)

In this community 9 days
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town St. Louis 918
(If outside city or town limits, write "RURAL")

(d) Street No. 4555a Swan Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Caleb Leslie Orsborn

3. (b) If veteran, name war Unknown

3. (c) Social Security No. 430-24-5963

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Fleecy Orsborn

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased December 119 11891
(Month) (Day) (Year)

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

52 6 22 hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Caleb Orsborn

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

14. Maiden name Sarah Ash

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

16. (a) Informant Paul Ulmer

(b) Address 4555a Swan

17. (a) Removal (b) Date thereof 7-11-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hoxie, Arkansas
Albert H. Hoppe

18. (a) Signature of funeral director _____

(b) Address 4700 Washington Blvd.

19. (a) JUL 11 1944 (b) F. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1944 hour 10:50 minute P M.

21. I hereby certify that I attended the deceased from July 2, 1944, to July 10, 1944
that I last saw him alive on July 10, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

internal hemorrhage
abdominal cavity

Due to aneurysm abd.

arterio-sclerosis

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

Major findings: _____

Of operations _____

Of autopsy aneurysm abdominal cavity

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature F. R. Bredel (M. D. or other) _____

Address BARNES HOSPITAL Date signed 7-11-44

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.....

Albert G. Hoffe

Licensed Embalmer No. 2971

P.O. Address.....

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.