

S. No. 2
M-5-43
5-17-39
I X36671

FILED SEP 30 1946

Registration District No. **30**

Primary Registration District No. **6076**

Registrar's No. **1988**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Jennings**
(c) Name of hospital or institution:
564 Glorose Dr.
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Jennings**
(d) Street No. **564 Glorose Dr.**
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME **Mary Lucile Orr**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Cecil A. Orr** 6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **November 21, 1904**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 **10** **2** hr. min.

9. Birthplace **Parsons Kan.**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business _____

12. Name **Barney Rouch**

13. Birthplace **Decatur Ills**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary O'Connor**

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

16. (a) Informant **Cecil A. Orr**

(b) Address **564 Glorose Dr**

17. (c) **Burial** (b) Date thereof **9/25/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Math Hermann & Son**
2161 East Fair Ave

(b) Address **9-25-46** (b) **Arthur J. Allen**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **23**,
year **1946** hour **12:30** PM minute _____ M.

21. I hereby certify that I attended the deceased from **July 2**
1944 to **September 23, 1946**
that I last saw her alive on **Sept 20**, 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**
Cerebral Haemorrhage
arterio Sclerosis
Due to _____
Due to _____

Duration
4 days
4 years

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

Major findings:
Of operations **none**
Of autopsy **none**

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) **none**
(b) Date of occurrence _____
(c) Where did injury occur? _____
(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 **H. J. Miller** (M. D. or other) _____
Address **9404 Broadway** Date signed **9/23/46**

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

MOTHER FATHER

DCT 9 1946

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 William G. Bushholz
Licensed Embalmer No. 2110
P. O. Address St. Louis, 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.