

FILED FEB 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5852

929

BIRTH NO. _____ REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY ST. CHARLES	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'FALLON RURAL		c. LENGTH OF STAY (in this place) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'FALLON RURAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) RAYMOND (First)		b. (Middle) — c. (Last) ORF	
4. DATE OF DEATH (Month) (Day) (Year) FEB. 12 1949		5. SEX M 6. COLOR OR RACE W	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ()		8. DATE OF BIRTH DEC. 6. 1947	
9. AGE (In years last birthday) 1 10. YEAR (Days) 1		11. BIRTHPLACE (State or foreign country) ST. CHARLES Mo	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME CLARENCE ORF	
13b. MOTHER'S MAIDEN NAME WILKE		14. NAME OF HUSBAND OR WIFE —	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT'S SIGNATURE OR NAME CLARENCE ORF O'FALLOY		ADDRESS Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart disease since birth ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) — DUE TO (c) — II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 115	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Dec 6 , 1947, to Feb. 12 , 1949, that I last saw the deceased alive on Jan 15 , 1949, and that death occurred at 4:00 p m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Lawrence S. Behay M.D. O		23b. ADDRESS O'Fallon Mo	
23c. DATE SIGNED 2-14-49		24a. BURIAL, CREMATION REMOVAL (Specify)	
24b. DATE FEB. 14-1949		24c. NAME OF CEMETERY OR CREMATORY ASSUMPTION	
24d. LOCATION (City, town, or county) (State) O'FALLON Mo		25. FUNERAL DIRECTOR'S SIGNATURE Earl Keitely ADDRESS O'Fallon Mo	
DATE REC'D BY LOCAL REG. Feb 14 - 49		REGISTRAR'S SIGNATURE Earl Keitely 280	

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed FEB 18 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. K. Athy

Licensed Embalmer No. 827

P. O. Address Fallers 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.