

FILED FEB 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3671

BIRTH NO. _____ REG. DIST. NO. 364 PRIMARY REG. DIST. NO. 4533 Registrar's No. 1

1. PLACE OF DEATH a. COUNTY <u>Warren</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Warren</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wright City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Wright City</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Clarence</u>		b. (Middle) _____ c. (Last) <u>Ordelheide</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 26 1950</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>April 9 1900</u>		9. AGE (In years last birthday) <u>49</u> # UNDER 1 YEAR Months _____ # UNDER 12 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Warren Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Henry Ordelheide</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Mestmaker</u>	
14. NAME OF HUSBAND OR WIFE <u>Nellie Ordelheide</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Nellie Ordelheide</u> ADDRESS <u>Wright City MO</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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) _____		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 <u>May 30, 1949</u> , to <u>Jan 24, 1950</u> , that I last saw the deceased alive on <u>Jan 24, 1950</u> , and that death occurred at <u>2 P</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>Mark Campbell MD</u> (Degree or title)		23b. ADDRESS <u>Wright Co Mo</u>	
23c. DATE SIGNED <u>1-27-50</u>		24a. BURIAL, CREMATION, REMOVA (Specify) <u>Burial</u>	
24b. DATE <u>Jan 29 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wright City Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Wright City Mo</u>		DATE REC'D BY LOCAL REG. <u>1/27/50</u>	
REGISTRAR'S SIGNATURE <u>Mrs. F. W. Hughes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Nieburg Furn & Und Co</u> ADDRESS <u>Wright City MO</u>	

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

90

APR 25 1950

MAY 3 1950

District Health Officer No. 9,
FEB 10 1950
RECEIVED

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, of _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Julius J. Nieburg

Licensed Embalmer No. *3366*

P. O. Address *Wright City, 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.