

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 19 1955

State File No. **33447**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4110</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>5 YEARS</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NORA RAY REST HOME</u>				e. STREET ADDRESS (If rural, give location) <u>3433 CHARLOTTE STREET</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CATHERINE</u> b. (Middle) <u>C.</u> c. (Last) <u>ORR</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>SEPT. 20, 1955</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB. 20, 1867</u>	9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Month: _____ Days: _____	IF UNDER 1 HRS. Hour: _____ Min: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>OTTAWA, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>MIKE SULLIVAN</u>		13b. MOTHER'S MAIDEN NAME <u>BRIDGETT UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>ROBERT JOHN ORR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>EARL T. ORR</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 years</u> <u>23 1/2</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min)		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>7-1-55</u> , 19 <u>55</u> , to <u>9-20-55</u> , that I last saw the deceased alive on <u>9-20-55</u> , and that death occurred at <u>10:05 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank Paul Laurezana, M.D.</u>				23b. ADDRESS <u>428 South White Ave</u>		23c. DATE SIGNED <u>9-20-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>SEPT. 20, 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>STREATOR, ILLINOIS</u>	
DATE REC'D BY LOCAL REG. <u>9-21-55</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Newcomer Sons</u>			
				ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Frank Paul Laurezana

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.....
Signature of Student Embalmer

Signed..... *John B Lewis*

Licensed Embalmer No. *48*

P. O. Address *HC W*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.