

FILED FEB 4 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 1102
Registrar's No. 69

BIRTH NO. _____		REG. DIST. NO. 141		PRIMARY REG. DIST. NO. 3025		Registrar's No. 69	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>WEST PLAINS</u>		c. LENGTH OF STAY (In this place) <u>37 YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>WEST PLAINS</u>		d. STREET ADDRESS (If rural, give location) <u>707 Johnson</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-2-1958</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ORAN L</u>		b. (Middle) <u>ABORN</u>		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <u>1-2-1958</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>		8. DATE OF BIRTH <u>7-4-1890</u>	
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u>		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>O. L. Aborn</u>			13b. MOTHER'S MAIDEN NAME <u>URS</u>			14. NAME OF HUSBAND OR WIFE <u>HETTIE Aboern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs O L Aboern, West Plains 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. 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>Hemiplegia Left Side</u> DUE TO (c) _____ 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 mos. 2 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				20. AUTOPSY? <u>0</u> 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) (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>Dec 31, 1957</u> , to <u>Jan 2, 1958</u> , that I last saw the deceased alive on <u>Jan. 2, 1958</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Richard A. Smith D.O.</u>		23b. ADDRESS <u>913 W. Main, West Plains, Mo</u>		23c. DATE SIGNED <u>1-30-58</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>18</u>		24b. DATE <u>1-4-58</u>		24c. NAME OF CEMETERY OR CREMATORY <u>OAK Lawn</u>		24d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>	
DATE REC'D BY LOCAL REG. <u>2-3-58</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robersons West Plains Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 5 1958

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

A. L. Roberts

Licensed Embalmer No. *3437*

P. O. Address *Westhampton*

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.