

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003349
STATE FILE NUMBER

801

FILED FEB 16 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webster Groves</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Gen.</u>		Length of stay in lb <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>361 Oakwood</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN CASPER ORMS</u>			4. DATE OF DEATH Month Day Year <u>Jan. 21, 1959</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1877</u>
9a. AGE (In years last birthday) <u>81</u>		9b. IF UNDER 1 YEAR Months Days Hours Min.	9c. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tooling</u>	11. BIRTHPLACE (City and state or country) <u>Johnstown, Penn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Norris D. Orms</u>	13b. MOTHER'S MAIDEN NAME <u>Susan Glitsch</u>
14. NAME OF HUSBAND OR WIFE <u>Dora Orms</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>492-10-5576</u>
17. INFORMANT <u>John N. Orms, 361 Oakwood</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Volvulus of the lower ileum with gangrene of the small intestine</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>570.3</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <u>7:25 AM Jan 20 1959</u> and last saw ^{him} alive on <u>Jan 21, 1959</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Vincent J Townsend MD</u>		22b. ADDRESS <u>3101st Sutton Ave Maplewood, Mo</u>	
22c. DATE SIGNED <u>1-22-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>1-24-59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	
23d. LOCATION (City, town, or country) (State) <u>St. Louis Co., Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Parker-Aldrich Webster Groves</u>	
25. DATE RECD. BY LOCAL REG. <u>JAN 23 1959</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>msb</u>	

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 *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Madeth Grove*

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.