

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3011 STATE FILE NUMBER 61-011348

AMENDED FILED APR 14 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>Over 2 yrs. - 4 mos</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5272 Washington Avenue</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Anderson Orr</u>		4. DATE OF DEATH Month Day Year <u>March 30, 1961</u>	

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/96</u>	9. AGE (last birthday) <u>64 years</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	11. BIRTHPLACE (City and state or country) <u>Tennessee (Memphis)</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Franklyn Y. Anderson</u>		13b. MOTHER'S MAIDEN NAME <u>Frances Shelton</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Orr</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO

17. INFORMANT Address
Mrs. H. Sherman, 412 Luther Ct. Glendale Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral thrombosis

DUE TO (b) Cerebral arteriosclerosis

DUE TO (c) 332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Chronic Brain Syndrome due to senility

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

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 Nov. 24, 1958 to March 30, 1961 and last saw her/him alive on March 30, 1961
Death occurred at 5:05A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Thomas Thale MD

22b. ADDRESS
5100 Arsenal St.

22c. DATE SIGNED
3/30/61

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE
3/31/1961

23c. NAME OF CEMETERY OR CREMATORY
Lake Charles Cemetery

23d. LOCATION (City, town, or county) (State)
St. Louis County, Mo.

24. FUNERAL DIRECTOR ADDRESS
Parker-Aldrich, Webster Groves, Mo.

25. DATE RECD. BY LOCAL REG.
MAR 30 1961

26. REGISTRAR'S SIGNATURE
Carl Smith, M.D.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

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 Wabster 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.