

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-040585

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10208

STATE FILE NUMBER

FILED NOV 15 1962

VS 300
Rev. 4/59

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DATE AMENDED
12/5/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF
7/12/1812

SHOULD READ
7/12/1912

ITEM NO. 8

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT
Birth Record
Funeral Director
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in lb	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
St. Louis, Mo.		St. Louis, Mo.			Missouri			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		4265 Wyoming		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 4265 Wyoming		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH Month Day Year		
Dorothy Marie Orlick						, 1912 Oct. 23, 1962		
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR	
female	white		Jul. 12, 1912	50	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		
Tavern Owner				Illinois		USA		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE		
Thos. G. Holland			Norma Richardson			Arthur C. Orlick		
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				
no		none		unk Arthur C. Orlick 4265 Wyoming, St. Louis, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)				DUE TO (b)				
Hepatic coma as a result of				Cirrhosis.				
DUE TO (c)				581.0				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days.		
						<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown		
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 a.m. p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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 _____, to _____ and last saw her/him alive on _____.								
Death occurred at <u>12:15 a.m.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Joseph M. Jones</i>				Degree or title <i>Secretary</i>		22b. ADDRESS <i>1300</i>		22c. DATE SIGNED <i>10-25-62</i>
23. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
Cremation		10-26-62	Missouri Crematory		St. Louis, Mo.			
24. FUNERAL DIRECTOR Southern Funeral Home				ADDRESS		25. DATE RECD. BY LOCAL REG. OCT 25 1962		26. REGISTRAR'S SIGNATURE <i>Ward Smith, M.D.</i>

*Cornier
St Louis*

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 *Howard C. Hill*

*ABdominal
Autopsy Performed*

Licensed Embalmer No. *4347*

P. O. Address *6322 So. Grand*

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.

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St. Louis
Missouri
State Board of Health
Division of Health Services
1111 Olive Street
St. Louis, Missouri 63101
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