

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044702  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11703

**FILED DEC 14 1962**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

12-10-62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

as record

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Funeral Director

ITEM NO. SHOULD READ

13 James Reginald Ormrod

14 Sarah W Armrod

USE BLACK INK OR TYPEWRITER RIBBON

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	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>709 S. Skinker Blvd</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>709 S. Skinker</u>
3. NAME OF DECEASED (Type or print) <u>REGINALD M.C. ORMROD</u>		First Middle Last	4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>62</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>3/31/1897</u>
9. AGE (last birthday) <u>65</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during <u>President</u> life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	11. BIRTHPLACE (City and state or country) <u>Whestham, Wales</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>James Reginald Ormrod</u>	
13b. MOTHER'S MAIDEN NAME <u>Blanch Mortimer</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah W. Ormrod</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.	17. INFORMANT <u>Dr. Robert Paine 3720 Washington</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		<u>163x</u>	
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 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 <u>6/26/50</u> to <u>12/5/62</u> and last saw her/him alive on <u>12/5/62</u> Death occurred at <u>11:19 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert Paine</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>3720 Washington St Louis</u>	22c. DATE SIGNED <u>12/6/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/7/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> (State)
24. FUNERAL DIRECTOR <u>Lupton Chapel, Inc 7233 Delmar Blvd</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 6 - 1962</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

1930

**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 Clarence H. Murray

Licensed Embalmer No. 4611

P. O. Address H. Lewis Mo

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.

Vertical text on the right edge of the page, possibly a stamp or reference number.