

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032393

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4517 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB
AMENDED

FILED SEP 11 1963

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|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 5 yrs | c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3008 E. 69 St. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3008 E. 69 St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Hattie Orr | | | 4. DATE OF DEATH Month Day Year August 12, 1963 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-23-1878 |
| 9. AGE (last birthday) 85 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Strout, Illinois |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME John Bum | |
| 13b. MOTHER'S MAIDEN NAME Mary Borrowman | | 14. NAME OF HUSBAND OR WIFE Dr. Charles Orr | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. [REDACTED] | 17. INFORMANT Address Mrs. R. Stevens 3008 E. 69 St. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| DUE TO (b) Arteriosclerotic Heart Disease | | | Years |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis | | | 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 type="checkbox"/> NO <input checked="" 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 8-12-63 to 8-12-63 and last saw him her alive on 8-12-63 Death occurred at 1:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) | | 22b. ADDRESS Suite 300 Research Medical Office Bldg; 6400 Prospect | 22c. DATE SIGNED 8-13-63 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 8-14-1963 | 23c. NAME OF CEMETERY OR CREMATORY Newton Cemetery | 23d. LOCATION (City, town, or county) (State) Nevada, Missouri |
| 24. FUNERAL DIRECTOR Muehlebach 6800 Troost | | 25. DATE RECD. BY LOCAL REG. 8-13-63 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

Dr. Long
6400 Pleasant
Law 3 - 2852

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 Robert J. Landes

Licensed Embalmer No. 5103

P. O. Address K. C. 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.