MAY 23 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12164

1. PLACE OF DEATH
County Davies — Registration District No. 257 — File No.
Township Grand River — Primary Registration District No. 5350 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Jesse F. Orten
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Polly Ann Orten

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 18-1867

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
63	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Ill.

PARENTS
10. NAME OF FATHER Wm Orten
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Virginia
12. MAIDEN NAME OF MOTHER Mary Ann Harbor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ill.

14. INFORMANT W. M. Orten
(Address) Jameson, Mo.

15. FILED April 26, 1930. Mrs. L. L. Henderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 25 - 1930

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to April 25th, 1930 that I last saw him alive on April 25th, 1930, and that death occurred, on the date stated above, at 3:45 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) J. B. Graham, M. D.
, 19 (Address) Jameson, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Prairie Valley — DATE OF BURIAL: 4/26 1930

20. UNDERTAKER: H A Hope — ADDRESS: Gallatin

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.