

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

Do not use this space.

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File No. _____
Registered No. **6155**
St. _____ Ward _____

1. PLACE OF DEATH
County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City _____ (No. **6th Infirmary**)

2. FULL NAME **George Orde**
(a) Residence No. **1508 N 8.** St. **13** Ward. _____
(Usual place of abode) _____ (If nonresident, give city or town and State)
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 **white** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **s**
6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Apr 1857**
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
apr 73 **Unknown**
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. **blacksmith**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) **mo.**
(STATE OR COUNTRY)

10. NAME OF FATHER **John Orde**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER **Ann Murphy**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)

14. INFORMANT **Mrs. Geo. G. Linger**
(Address) **5846 Poplar St.**

15. FILED **May 1930**
REGISTRAR **W. C. St. Martin**

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-23 1930**
17. I HEREBY CERTIFY, That I attended deceased from **6-1**, 19**30**, to **6-23**, 19**30**, that I last saw him alive on **6-23**, 19**30**, and that death occurred, on the date stated above, at **6:30 P.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic nephritis
93c
82A
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) **Old cerebral Hemorrhage**
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Altheil**, M. D.

6-24, 1930 (Address) **1608 Arsenal**
*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.

49. PLACE OF BURIAL, CREMATION, OR REMOVAL **Calvary Cemetery** DATE OF BURIAL **June 25 1930**

20. UNDERTAKER **John A. Genteman** ADDRESS **5077 Durant**

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.

