

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.

NOV 24 1930

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

Do not use this space.

33226

22

1. PLACE OF DEATH

County Jackson Registration District No. 403
Township Brookings Primary Registration District No. 5557
City St. James (No. Municipal)

File No.
Registered No.
St. (Ward)

2. FULL NAME

Edolph Orby
(a) Residence. No. St. 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 M 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5-9 - about

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer _____

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

PARENTS
10. NAME OF FATHER _____
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER _____
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT M. O'Rourke
(Address) Municipal Farm

15. FILED 10-11, 1930 D. D. Hobbs M.D. REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1930 10 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h..... alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myo carditis
131
932 (duration) yrs. mos. ds.
CONTRIBUTOR Chronic indurated
(SECONDARY) myocarditis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT A PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

19. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Stanley H. Sp... M. D.
, 19____ (Address) St. James

*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 Maple Hill DATE OF BURIAL Oct 30 1930

20. UNDERTAKER Rose Henderson ADDRESS City

