

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Haw
City H.C. No.

Registration District No. 389
Primary Registration District No. 3002
(No. St. Louis Hospital)

File No. 25226
Registered No. 1000
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Webb City Mo. St. _____ Ward _____
(Usual place of abode)

[IMEL]

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 <u>M</u>	4. COLOR OR RACE <u>wh.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 8 1912</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>19</u>	<u>2</u>	<u>19</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work <u>Schoolboy.</u>				
(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) Missouri

PARENTS	10. NAME OF FATHER <u>Wm. H. Ormel</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo.</u>
	12. MAIDEN NAME OF MOTHER <u>Effie E. Reed</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Mo.</u>

14. INFORMANT Wm. H. Ormel
(Address) Webb City Mo.

15. FILED 7/27 1931 M. J. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-27 1931

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:
accidental broken neck Webb City Mo. 194B

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Brok neck while swimming
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

IF AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Stanley M. Hall, M. D.

7/27 1931 (Address) Deputy Coroner

*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 <u>Webb City Mo.</u>	DATE OF BURIAL <u>7 28 19 31</u>
20. UNDERTAKER <u>Mrs. P. S. Foister</u>	ADDRESS <u>H.C. Mo.</u>

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.

