

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

Do not use this space.

28483

3611

1. PLACE OF DEATH
 County Jackson Registration District No. 288
 Township Kaw Primary Registration District No. 3002
 City Kansas City (No. 4222 Harrison) St. _____ Ward _____

2. FULL NAME Lydia Lulu Orton
 (a) Residence. No. 4222 Harrison St. 6 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 Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank E. Orton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby. 19, 1886

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	45	6	8	

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

9. BIRTHPLACE (CITY OR TOWN) St. Paul
 (STATE OR COUNTRY) Minnesota

10. NAME OF FATHER Frank E. Orton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York City
 (STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER Pauline Haller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Bloomington
 (STATE OR COUNTRY) Illinois

14. INFORMANT Frank E. Orton
 (Address) 4222 Harrison

15. FILED 8/27 1931 M. M. Lawrence
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-27-1931

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:
Cancer Uterus
48 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Stanley M. Slack, M. D.
8/27 1931 (Address) 1015 E. Crown

*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 St. Mariah Cemetery DATE OF BURIAL 8-29-1931

20. UNDERTAKER Stueve + McCre ADDRESS 2285 Livcham Plaza

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.

