

1-14024
OCT 16 1939

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

33427
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773
(b) Township St. Francois Primary Registration District No. 6015A
(c) City Farmington (d) Street No. State Hospital No. 4 St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Orville Lomax

(a) Residence, No. _____ County Farm St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Single

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1910 ? ?

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
29 ? ?

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dunklin County Missouri

FATHER 13. NAME not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Effie Hendrixson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT Records of State Hospital No. 4 (ADDRESS) Farmington, Mo.

18. BURIAL PLACE Cadwell 9/13/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Kearney Co Cadwell Mo

20. FILED Sept 30, 1939 F. J. Robinson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-12, 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-23, 1938, to 9-12, 1939

I last saw him alive on 9-11, 1939 Death is said to have occurred on the date stated above, at 5:40a.m.

The principal cause of death and related causes of importance were as follows:

Status Epilepticus
Secondary to Idiopathic
Epilepsy

Date of onset

Other contributory causes of importance: \$0

Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? Yes
If so, specify Paul J. Shradar M.D.
(Signed) _____ (Address) Farmington, Mo

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed was not Embalmed
....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.