FILED OCT 11 1940

S. No. 2
—11-10-39
v. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31023

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3586

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1716 Penn St.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 15 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

0

(d) Street No. 1716 Penn
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Julia E. Orsborne

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Henry Orsborne

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased October 9 1891
(Month) (Day) (Year)

8. AGE: Years 48 Months 11 Days 4 If less than one day hr. min.

9. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 1

11. Industry or business Same 0

FATHER
12. Name James Moorehead
13. Birthplace Illionois
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Isabelle Chamber
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William H. Orsborne
(b) Address 1716 Penn St. K.C.Mo.

17. (a) Burial (b) Date thereof Sept. 14, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Rose & Henderson
(b) Address 4139 E. 15th St. K.C.Mo.

19. (a) Sept. 13, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
year 1940 hour 3:55 minute A. M.

21. I hereby certify that I attended the deceased from July 20, 1940, to Sept. 13, 1940; that I last saw her alive on Sept. 13, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Endocarditis & Myocarditis	
Due to Chronic Parenchymatous Nephritis	
Due to	
Other conditions 9 (Include pregnancy within 3 months of death) 13	

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 1

23. Signature James P. Henderson (M. D. or other)
Address 807-9 Argyle Bldg Date signed 9/13/40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed [signature]

Licensed Embalmer No. 29 5-5

P. O. Address R.C. Mo

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

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