

S. No. 2
4-13-40
7-5-17-39
X231

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Meyer 32004

State File No. _____

Registrar's No. 716

FILED OCT 10 1940 316

Registration District No. _____

Primary Registration District No. 2201

19
3
6

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

1. PLACE OF DEATH: GREENE
 (a) County _____
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Burge Hosp.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 hours
(Specify whether years, months or days)
 In this community 25 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Greene
 (c) City or town Springfield
(If outside city or town limits, write "RURAL")
 (d) Street No. 999 St. Louis, St.
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Clell Erwin Orchard

3. (b) If veteran, name war no 3. (c) Social Security No. 493-16-42

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah L. Orchard 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased December 31 1886
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>53</u>	<u>8</u>	<u>0</u>	<u>0</u>	hr. _____ min.

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

10. Usual occupation Druggist

11. Industry or business Orchard Drug Store

12. Name James Orchard

13. Birthplace Carthage Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Maurice Orchard

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Sept. 3 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eastlawn Cem.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) Sept. 3, 1940 (b) M.E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 1
23 year 1940 hour 7 minute a. M.

21. I hereby certify that I attended the deceased from Sept 1, 1940, to Sept 1, 1940
 that I last saw him alive on Sept 1, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial Infarction

Due to _____
 Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? ACIL

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature [Signature] (M. D. or other) _____

Address Springfield, Mo. Date signed Sept 3 1940

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

M. L. Canaday

Licensed Embalmer No. *34 B4*

P. O. Address *Springfield, Ma*

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, fact should be so stated above.

X