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K26390

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. 27601

Registration District No. 1 SEP 12 1941

Primary Registration District No. 1002

Registrar's No. 3259

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Vineyard Park Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution seven days (Specify whether

In this community 40 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Missouri (b) County Jackson

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

(d) Street No. 743 West 35th (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mrs. Amelia Orendorff

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Albert Orendorff

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

7. Birth date of deceased July 12, 1876 (Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 17 If less than one day hr. min.

9. Birthplace House wife Lawrence Kans (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name George Feil
13. Birthplace Alsasae Lorraine 5 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Antonia Kellerman
15. Birthplace Lyons France 5 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Betty Clarke

(b) Address 714 West 35th

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-41 (Month) (Day) (Year)

(c) Place: burial or cremation [illegible]

18. (a) Signature of funeral director Quirk and Tabin Co.

(b) Address 20 West Linwood

19. (a) 8/31/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29 year 1941 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Deputy Coroner, 19 , to , 19 ; that I last saw alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Acute pulmonary congestion

Due to Hypertensive heart disease

Fracture of left femur & left humerus

Other conditions (Include pregnancy within 3 months of death) Injury by fall

Major findings:
Of operations
Of autopsy

Duration

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) Accident

(b) Date of occurrence 8-22-41

(c) Where did injury occur? K.C. (City or town) Mo (County) (State) 123

(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

23. Signature [illegible] (M. D. or other) 3

Address K.C. Mo. Date signed

(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.....

Licensed Embalmer No. 4097

P. O. Address.....K. C. Mo,

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

If this body is not embalmed, fact should be so stated above.

No. 2B
-8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27601

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3259

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

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

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mrs. Amelia Orendorff

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day or min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day
year hour minute M.

21. I hereby certify that I attended the deceased from
19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to: Fracture of left femur + left humerus	
Due to: Injury by fall	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

186a
18

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) Accident
(b) Date of occurrence 8-22-41
(c) Where did injury occur? KD At home Mo
(City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
Fell downstairs at home
(Specify type of place)
While at work? (c) Means of injury 74-3 Vest 35 Fall

23. Signature Victor F. Ruhlen (M. D. or other)
Address Date signed