

No. 2
1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

39975

State File No. _____

FILED JAN 24 1942 791

Primary Registration District No. _____ Registrar's No. 9685

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5349 Pershing Ave.
(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 Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5349 Pershing Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Ora Dalrymple Orr

3. (b) If veteran, name war No. 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 5 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 5 29 hr. min.

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

10. Usual occupation Housework

11. Industry or business Own Home

12. Name John Orr

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

14. Maiden name Mary E. Clayton

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

16. (a) Informant Mrs. Mable Pruett

(b) Address 5349 Pershing Ave.

17. (a) Burial (b) Date thereof 12-8-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) DEC 7 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4
year 1941 hour 30 minute 0 M.

21. I hereby certify that I attended the deceased from Dec 3
1941 to Dec 4 1941
that I last saw her alive on Dec 3 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive myocarditis chronic
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? _____

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

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

Address 4624 Taylor Date signed _____

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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.....

Gay W. Wilkerson

Licensed Embalmer No.....

3575

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, fact should be so stated above.