

No. 7
8-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41691
Registrar's No. 20

Registration District No. 12 344

Primary Registration District No. 5815

1. PLACE OF DEATH:

(a) County MORGAN
(b) City or town RURAL - VERSAILLES MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Haw Creek Ins.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community LIFE TIME (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County MORGAN
(c) City or town RURAL HAW CREEK
(If outside city or town limits, write "RURAL")
(d) Street No. 6 MI. N.W. OF VERSAILLES
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME ORSINO JOHN ROSS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife SALLIE DANIELS 6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased JUNE 13 1855
(Month) (Day) (Year)

8. AGE: Years 89 Months 5 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name PERRY ROSS
13. Birthplace COOPER CO MO (City, town, or county) (State or foreign country)
14. Maiden name LUCY ANN BOLINGER
15. Birthplace COOPER CO MO (City, town, or county) (State or foreign country)

16. (a) Informant Shelby Ross
(b) Address Glenn, Mo

17. (a) BURIAL (b) Date thereof 12-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Freeman Cemetery

18. (a) Signature of funeral director Dr. F. Caldwell
(b) Address Versailles Mo

19. (a) Dec 18, 1944 (b) Henry Kipp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 17
year 1944 hour 2 minute P M.

21. I hereby certify that I attended the deceased from June 1, 1944 to Dec 12, 1944
that I last saw him alive on Dec 11, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial sclerosis Duration 5 yrs.

Due to _____

Due to _____ 97

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) (e) Means of injury 0

23. Signature A. J. Green (M. D. or other) _____

Address Versailles Mo Date signed 12/13/44

Duration
Physician
Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 7
District of Columbia
1-13-45
12-44-1541

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 *E. F. Keenan*

Licensed Embalmer No. *1546*

P. O. Address *Keenan's*

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.