

FILED APR 23, 1945
Registration District No. 1001

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: A.C. Convalescent Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 months
(Specify whether)

In this community 45 years
years, months or days

3. (a) PRINT FULL NAME John Maxwell Orter

3. (b) If veteran, name war no

3. (c) Social Security No. 492-14-7878

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Angie 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Jan 12 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months 2 Days 27 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business labor

12. Name George W Orter

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

14. Maiden name Mary A Reinde

15. Birthplace Jackson County Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Cecily Orter

(b) Address 910 E 29 St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 10 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director D W Newcomer

(b) Address 1401 Bush Creek Rd

19. (a) 4-10-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 3200 Norledge
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8 year 1945 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from 9-4-44 to 4-8-45; that I last saw him alive on 4-7-45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

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)

(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

23. Signature Maurice (M. D. or other) Address 2200 Norledge Date signed 4-10-45

SEP 4 1945

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

Charles H. Hickey

Licensed Embalmer No. *1767*

P. O. Address. *Kansas City*

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.