

S. No. 2
M-8-43
v. 5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 19 1945
Registration District No. 217

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. 5787

State File No. 14010
Registrar's No. 24

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

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: R#2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution All Of Life (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Opal May Orman
3. (b) If veteran, name war. ----- 3. (c) Social Security No. -----

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife ----- 6. (c) Age of husband or wife if alive ----- years
7. Birth date of deceased January 14th 1945
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>2</u>	<u>21</u>	hr. <u>-----</u> min. <u>-----</u>

9. Birthplace R#2 Mississippi Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business -----

MOTHER FATHER
12. Name Comer F. Orman
13. Birthplace Hickman Co. Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Eveleen Burns
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Comer Orman
(b) Address Charleston, Mo. R#2

17. (a) Burial (b) Date thereof 4-5-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maynard, Diehlstadt, Mo

18. (a) Signature of funeral director John F. Hummel
(b) Address Charleston, Mo.

19. (a) 4/1/45 (b) Mrs Lou Mae
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Miss. 67
(c) City or town Charleston, (rural)
(If outside city or town limits, write "RURAL")
(d) Street No. R#2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5th
year 1945 hour 12 minute 20 A. M.

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

Immediate cause of death Accidental asphyxiation
Duration -----

Due to sleeping in same bed as parents - found dead

Due to next morning - no illness previous

Other conditions (include pregnancy within 3 months of death) -----

Major findings: 8 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of operations -----
Of autopsy 18219

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? -----

While at work? (Specify type of place) (e) Means of injury -----
23. Signature John F. Hummel Date signed 4-5-45
Address Charleston, Mo.

1257

RECEIVED

District Health Office No. 2,

District File Number

445-585

Date Filed

4/14/45

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.

Not embalmed

Signed _____

Licensed Embalmer No. _____

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.