

FILED JUN 11 1946

State File No. \_\_\_\_\_

Registration District No. 140

Primary Registration District No. 3024

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Howard  
(b) City or town Fayette  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Lee Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10 Weeks  
In this community Boone Co. All her life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone  
(c) City or town Harrisburg  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT

FULL NAME Orpha Wilhite Hord

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

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

6. (b) Name of husband or wife Watt Hord 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased July 31, 1890  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>9</u>	<u>17</u>	hr. ____ min.

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

10. Usual occupation House-wife

11. Industry or business \_\_\_\_\_

12. Name Eyverett Wilhite

13. Birthplace Boone Co. Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Caldonia Gibson

15. Birthplace Boone Co. Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Watt Hord  
(b) Address Harrisburg, Missouri

17. (a) Burial (b) Date thereof 5/20/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrisburg Cemetery

18. (a) Signature of funeral director Ralph A. Carr  
(b) Address Fayette, Missouri

19. (a) 5-22-46 (b) Dorothy Fern Schen  
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th  
year 1946 hour 3:00 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from 2-10 1946 to 5-18 1946  
that I last saw her alive on 5-18 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus Duration 1 day  
Due to Diabetes 10 yrs

Other conditions Confusion 1 wk  
(Include pregnancy within 3 months of death)  
of left leg

Major findings: Of operations \_\_\_\_\_  
Of autopsy (9)

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 W. A. Blain (M. D. or other) M.D.  
Address Fayette Mo. Date signed 5-21-46

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

15369

RECEIVED

District Hearing \_\_\_\_\_

District File Number \_\_\_\_\_

Date Filed 6-10-46

**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, ~~of~~ \_\_\_\_\_  
\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed Ralph A. Carr

Licensed Embalmer No. 3340

P. O. Address Fayette Mo

**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.