S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20106

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No. 797

1. PLACE OF DEATH: Buchanan
(a) County
(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: At his home. 917½ Patee Street, (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) Most of his life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri. (b) County Buchanan 11
(c) City or town St. Joseph- 1 (If outside city or town limits, write "RURAL")
(d) Street No. 917½ Patee Street 7 (If rural, give location)
(e) Citizen of foreign country? NO 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ORVILLE NEWTON ADDISON.
3. (b) If veteran, name war NO.
3. (c) Social Security No. not stated

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Wife Bertha May Addison
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased October (Month) 10th. (Day) 1884 (Year)

8. AGE: Years 62 | Months 8 | Days 4 | If less than one day hr. min.
9. Birthplace Cainsville, Missouri. (City, town, or county) 0 (State or foreign country)
10. Usual occupation Foreman- Morris Packing Co.
11. Industry or business Packing.
FATHER 12. Name Robert Addison
13. Birthplace Cainsville, Missouri. 0 (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Phoebe Scott
15. Birthplace Cainsville, Missouri. 0 (City, town, or county) (State or foreign country)
16. (a) Informant Bertha May Addison.
(b) Address 917½ Patee Street-
17. (a) Burial- (Burial, cremation, or removal) (b) Date thereof 6/16/47 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cemetery.
18. (a) Signature of funeral director Mrs. E.R. Lidenfadeu
(b) Address 602 South 10th. Street St. Jos, Mo.
19. (a) 6-30-47 (Date received local registrar) (b) L. L. Jenkins (Registrar's signature) 207

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th- year 1947 hour 1 minute 00 A.M.
21. I hereby certify that I attended the deceased from NOVEMBER 25, 1946, to MAY 20, 1947; that I last saw h. IM alive on MAY 20, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: ACUTE PULMONARY EDEMA	1 HOUR.
Due to: CHRONIC MYOCARDITIS	5 YRS.
Due to: HYPERTENSION	10 YRS.
Other conditions (Include pregnancy within 3 months of death) 93D	
Major findings of operations: NONE	
Of autopsy: NONE	

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 — 0

23. Signature Allen S. Herman (M. D. or other) M.D.
Address 1302 FARAON Date signed 6-15-47

(Licensed Embalmer's Statement on Reverse Side)

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 Mollie E. Lidenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St Joseph 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.