

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 1 1947
Registration District No. _____

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23254**
Registrar's No. **195**

Primary Registration District No. **5000**

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Highway No. 6 near Orick Mine 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
In this community Life
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Ora Dorman
(b) If veteran, name war _____ (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, divorced, Married
(b) Name of husband or wife Verda Sharr 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Dec. 9 1887
(Month) (Day) (Year)

8. AGE: Years 59 Months 7 Days 6 If less than one day
hr. _____ min. _____

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

10. Usual occupation City Employee

11. Industry or business _____

MOTHER FATHER { 12. Name James Dorman
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mary Phillips
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Verda Dorman
(b) Address Kirksville; Missouri

17. (a) Burial (b) Date thereof 7/17/47
(Burial, cremation, or removal) (Month) (Day) (Year)
Maple Hills Cmt.

18. (a) Signature of funeral director Dave Riley
(b) Address Kirksville; Missouri

19. (a) _____ (b) Mrs. Kate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Kirksville
(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 _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 15
year 1947 hour 10:00 minute A: _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death suicide by shooting himself in the head with a 12 ga. shot gun
Due to _____

Due to _____

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) Suicide
(b) Date of occurrence July 15, 1947
(c) Where did injury occur near Kirksville, Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
no.

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature Foster R. Ensey
Address Brookman, Mo. Date signed 7-15-47

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

RECEIVED
District Health Officer No. 10
District Est. Number 7-47-958
Date Filed JUL 27 1947

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.....

..... Kenneth Slavens, Registered Apprentice No. 418
working under my personal supervision.

Signed DEE Riley

Licensed Embalmer No. 4181

P. O. Address Kirkville, Missouri

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.

Registration District No. 1

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Ma Dorman

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 _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Dec 9 (Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days _____ (Less than one day _____ hr. _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

{ 14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-14-47 (b) Kate Lambert (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

23254