

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **22917**FILED JUL 30 1948
Registration District No. **228**Primary Registration District No. **5465**Registrar's No. **564**

1. PLACE OF DEATH:

(a) County **Greene**
 (b) City or town **Sp Rural north Campbell Sup**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **Duncan nursing home**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 Year** (Specify whether years, months or days)
 In this community **20 years**

3. (a) PRINT FULL NAME **Orlano Sims**

3. (b) If veteran, name war **no**
 3. (c) Social Security No. **no**

4. Sex **f** / 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive **27** years
 7. Birth date of deceased: **June 27 1855**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
95 0 12 hr. min.

9. Birthplace **W. Va.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **housewife**

11. Industry or business

12. Name **George Groves**
 13. Birthplace **unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Rachael Connes**
 15. Birthplace **unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Records**
 (b) Address **Klingner Funeral Home**
 17. (a) **burial** (b) Date thereof **7-11-48**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Maple Park**

18. (a) Signature of funeral director **J. W. Klingner**
 (b) Address **Springfield, Mo.**

19. (a) **7-11-48** (b) **W. E. Handley MD**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
 (c) City or town **rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Hi-way 66 west**
 (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 **9**
 year **1948** hour **5** minute **30 p.m.**

21. I hereby certify that I attended the deceased from **July 7, 1948** to **July 9, 1948**
 that I last saw him alive on **July 9, 1948**
 and that death occurred on the date and hour stated above. Duration

Immediate cause of death
Myocardial degeneration
Cardio-vascular degeneration
 Due to **gastroenteritis**
Burgers des.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **939**

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? Means of injury

23. Signature **Arthur K. Smith** (M. D. or other)
 Address **1630 N. Jefferson** signed **7-10-48**

PHYSICIAN

Underline the cause of death which should be charged statistically.

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

Max Rhodes

Licensed Embalmer No.

4071

H. O. Address

Springfield

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.