

FILED JAN 24 1949

Registration District No. 377

 MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 42835

Registrar's No. 2229

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Koch (Rural)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Robert Koch Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 yrs, 3 mos.
 (Specify whether
 In this community Life
 years, months or days)

3: (a) PRINT FULL NAME

Earl Nelson Orr3. (b) If veteran,
name war3. (c) Social Security No.
2

4. Sex Male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 7 12 1929
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
19 5 18 . hr. min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name Taylor Orr13. Birthplace Brookfield, Miss.
(City, town, or county) (State or foreign country)14. Maiden name Mary15. Birthplace Brookfield, Miss.
(City, town, or county) (State or foreign country)16. (a) Informant Hospital Records(b) Address Robert Koch Hospital17. (a) Burial (b) Date thereof 1-5-49
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Washington Park Cemetery18. (a) Signature of funeral director Athelin Bros. Mpls.(b) Address 3644 Linn Ave.19. (a) 1-4-49 (b) Hand & Linn
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1831 Bidella
 (If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December Day 31
 year 1948 hour 6:15 minute P M.

21. I hereby certify that I attended the deceased from
9.25, 1945, to 12.31, 1948
 that I last saw him alive on 12.31, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
 Duration ?

Due to _____
138

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

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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 R. Beem (M. D. or other) M. D.
 Address Robert Koch Hospital Date signed 1.1.49

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 Louis V. Coekin

Licensed Embalmer No. 2842

P. O. Address 3644 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.