

FILED JUN 20 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19204

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 542

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Jefferson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Meriden Rural</u>	
c. LENGTH OF STAY (in this place) <u>164 Days</u>		d. STREET ADDRESS (If rural, give location) <u>Rt. 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'Reilly VA Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Roy</u>	b. (Middle) <u>S.</u>	c. (Last) <u>ORR</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 17, 1949</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>November 28, 1890</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR (Months) <u>5</u>	IF UNDER 11 HRS. (Hour) (Min.) <u>19</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Lawrence, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Oscar Orr</u>	13b. MOTHER'S MAIDEN NAME <u>Fannie Bowker</u>	14. NAME OF HUSBAND OR WIFE <u>Edith Orr</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>O'Reilly Hospital Records, Springfield, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Dilatation</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic cor pulmonale</u> <u>Pneumothorax, left, chronic, spon-</u> DUE TO (c) <u>taneous</u> II. OTHER SIGNIFICANT CONDITIONS <u>Emphysema, vesicular, sub pleural and</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>Intra pulmonary, extreme, Tuberculosis pulmonary, Mod. adv. hilum area, right.</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from January 16, 1949, to June 17, 1949, that I last saw the deceased alive on June 17, 1949, and that death occurred at 9:55A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Paul L. Eisele, MD</u>	23b. ADDRESS <u>O'Reilly VA Hospital Springfield, Missouri</u>	23c. DATE SIGNED <u>June 17, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>June 18, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>unknown</u>	24d. LOCATION (City, town, or county) (State) <u>Topeka, Kansas</u>
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DATE REC'D BY LOCAL REG. <u>6-18-49</u>	REGISTRAR'S SIGNATURE <u>W.S. Handley, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Samuel Schaffel, 7 Home Springfield, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4594

P. O. Address Springfield, 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.