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FILED SEP 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27746

BIRTH NO. _____ REG. DIST. NO. 296 PRIMARY REG. DIST. NO. 4445 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Ray	
b. CITY (If outside corporate limits, write RURAL and give township) Orriok,		c. LENGTH OF STAY (In this place) 1		c. CITY (If outside corporate limits, write RURAL and give township) Orriok,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location) 1			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Shirley	b. (Middle) John	c. (Last) Dorton	(Month) Aug.	(Day) 13,	(Year) 49
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 6, 1901	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Garage	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U*S*A

13a. FATHER'S NAME James G. Dorton	13b. MOTHER'S MAIDEN NAME Dollie A. McMullin	14. NAME OF HUSBAND OR WIFE Mary Verell Dorton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Dorton
		ADDRESS Orriok, Mo.

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, asthma, 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) Sun shot Wound		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) in left side head DUE TO (c) self-inflicted		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		8976X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ASSIDENT SUICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) Orriok (COUNTY) Ray (STATE) Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 13 49-6a	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE John F. Baber ³	(Degree or title) Coroner	23b. ADDRESS Richmond, Mo.	23c. DATE SIGNED 8-14-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 15, 49	24c. NAME OF CEMETERY OR CREMATORY South Point	24d. LOCATION (City, town, or county) (State) Near Orriok, Mo.
DATE REC'D BY LOCAL REG. 8-15-49	REGISTRAR'S SIGNATURE Walter J. Larkin ²⁷²	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Good	ADDRESS Orriok, Mo.

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

RECEIVED AUG 22

District Health Officer No. 8

District File Number 849-1

Date Filed 8-30-49

MAR 21 1950

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 James C. Wallace

Signed _____
Student Embalmer

Licensed Embalmer No. 3921

P. O. Address 3803 Main
J.C. Wood

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.

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