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FILED APR 6 1951

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH 5474

State File No. 8178

BIRTH NO. _____ REG. DIST. NO. 132 PRIMARY REG. DIST. NO. 5474 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY Grundy		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Daviess	
b. CITY (If outside corporate limits, write RURAL and give township) Hickory Jefferson Twp		c. CITY (If outside corporate limits, write RURAL and give township) Gallatin	
c. LENGTH OF STAY (In this place) 3 Months		d. STREET ADDRESS (If rural, give location) ---	
d. FULL NAME OF HOSPITAL OR INSTITUTION 9 Miles S.W. Trenton, Mo.			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Franklin c. (Last) Orten			4. DATE OF DEATH (Month) (Day) (Year) March 17 1951		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Aug. 13 1892		9. AGE (In years last birthday) 58		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Missouri	

13a. FATHER'S NAME Jess F. Orten		13b. MOTHER'S MAIDEN NAME Polly Ann Daniels		14. NAME OF HUSBAND OR WIFE Lena Orten	
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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) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Cleo Wheeler, Hickory, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pyelitis			3 days	
		ANTECEDENT CAUSES				
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Urinary Retention DUE TO (c) Shaking of Brain			18 mos.	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 193X		20. AUTOPSY? YES <input 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 15, 1951, to Mar 17, 1951, that I last saw the deceased alive on Mar 16, 1951, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE J. B. Bailey (Degree or title) M.D.		23b. ADDRESS Jamesport, Mo.		23c. DATE SIGNED 3-22-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-20-1951		24c. NAME OF CEMETERY OR CREMATORY Prairie Valley Cemetery	
				24d. LOCATION (City, town, or county) (State) Daviess Co., Missouri	

DATE REC'D BY LOCAL REG. 3/20/51		REGISTRAR'S SIGNATURE Irene Fair		25. FUNERAL DIRECTOR'S SIGNATURE L. D. Johnson	
				ADDRESS Home Funeral Home Gallatin, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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



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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed.....
Student Embalmer

Licensed Embalmer No. 3307

P. O. Address Fall River, Mo.

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.