

FILED JUL 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18030

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>70</u>		PRIMARY REG. DIST. NO. <u>5375</u>		Registrar's No. <u>27</u>											
1. PLACE OF DEATH a. COUNTY <u>Clark</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clark</u>													
b. CITY (If outside corporate limits, give RURAL and give OR: TOWN <u>rural Des Moines</u>)		c. LENGTH OF STAY (in this place) <u>51 yrs</u>		c. CITY OR TOWN <u>Wayland</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph</u>				e. STREET ADDRESS (If rural, give location) <u>7230</u>													
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Mary</u>			b. (Middle) <u>Emma</u>			c. (Last) <u>Orr</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 5 1955</u>					
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>			8. DATE OF BIRTH <u>April 21, 1893</u>			9. AGE (in years last birthday) <u>62</u> If UNDER 1 YEAR Months Days If UNDER 4 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				BIRTHPLACE (City and State or Foreign Country) <u>College Springs Ia.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13a. FATHER'S NAME <u>David Rob. Little</u>				13b. MOTHER'S MAIDEN NAME <u>Almora Melvina Hedrick</u>				14. NAME OF HUSBAND OR WIFE <u>Willard Orr</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY NO. _____				17. INFORMANT'S SIGNATURE OR NAME _____				ADDRESS _____					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Bladder</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH <u>months</u>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____								21. HOW DID INJURY OCCUR? <u>181 X</u>					
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"/>													
22. I hereby certify that I attended the deceased from <u>July 3, 1955</u> , to <u>July 5, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>7:30 P m.</u> , from the causes and on the date stated above.																	
23a. SIGNATURE (Degree or title) <u>Perry S. Barton D.O.</u>						23b. ADDRESS <u>Kahoka, Mo</u>						23c. DATE SIGNED <u>7-6-55</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24b. DATE <u>July 7-55</u>				24c. NAME OF CEMETERY OR CREMATORY <u>Walt Cem.</u>				24d. LOCATION (City, town, or county) <u>Clark Co. Mo.</u> (State) _____					
DATE REC'D BY LOCAL REG. <u>7/8-55</u>				REGISTRAR'S SIGNATURE <u>JR Bridges</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Sutter</u>				ADDRESS <u>Kahoka</u>					

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Atis L. Gutter

Licensed Embalmer No. *296*

P. O. Address *...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.