

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040605
STATE FILE NUMBER

FILED NOV 21 1958 Registration District No. 383 Primary Registration District No. 5647 Registrar's No. 113

S. 300 4-
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Barry</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Freistatt</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Monett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Conval. Home</u>		Length of stay in lb <u>3 Mos.</u>	d. STREET ADDRESS <u>805 Frisco</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>Johanna</u> Last <u>Orton</u>			4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1875</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Madison County, Ark.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Joe Gray</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ritchie</u>		14. NAME OF HUSBAND OR WIFE <u>Edward Orton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Claude Orton, Monett, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
DUE TO (b) <u>Inanition & debilitation</u>					<u>7 days</u>
DUE TO (c) <u>Sepsis, due to hip fracture</u>					<u>6 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Fracture of left femur followed Staph infection</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>Fell in yard</u>			
20c. TIME OF INJURY Hour <u>5:30</u> Month <u>Sept</u> Day <u>28</u> Year <u>1958</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory street, office bldg., etc.) <u>about home</u>			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. CITY, TOWN, OR LOCATION <u>Freistatt Mo Lawrence Mo</u>			
21. I attended the deceased from Death occurred at <u>11:40 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.		21. I attended the deceased from <u>Aug 11 1958</u> to <u>Nov 3 1958</u> and last saw her <u>alive on Nov 3 1958</u>			
22a. SIGNATURE <u>David G. George DO 2</u>		22b. ADDRESS <u>McKean Clinic McKean, Mo</u>		22c. DATE SIGNED <u>11/5/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-6-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Fayetteville, Ark.</u>	
24. FUNERAL DIRECTOR <u>Mercer Funeral Home, Monett, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-7-58</u>		26. REGISTRAR'S SIGNATURE <u>Cecil Handrick</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Roy H. Menner*

Licensed Embalmer No. *4432*

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