

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026170

STATE FILE NUMBER

Registration-District No. 275 Primary Registration District No. 3053 Registrar's No. 129

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| 1. PLACE OF DEATH a. COUNTY <u>Shelby</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tolla</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Helms Co. Mem. Hosp.</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sawford</u> c. CITY OR TOWN <u>Cuba</u> d. STREET ADDRESS <u>N. W. 2</u> | |
| Length of stay in 1b <u>Life</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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|--|---|--|---|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Austin</u> Last <u>Orr</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>8-31-1882</u> | 9. AGE (last birthday) <u>76</u> | IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10a. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | 11. BIRTHPLACE (City and state or country) <u>Cuba, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Solomon Monroe Orr</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Sarah Angelina Page</u> | | 14. NAME OF HUSBAND OR WIFE <u> </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> </u> | | 17. INFORMANT <u>Sam C. Orr, Cuba, Mo.</u> | | |

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| 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>Cerebro-vascular Accident (Thrombosis)</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>15 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input 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.) | | | | | |
| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> Month, Day, Year <u> </u> | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>July 13, 1959</u> | | Death occurred at <u>3:30 A.M.</u> | | last saw her/him alive on <u>July 22, 1959</u> | | | | | |

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| 22a. SIGNATURE (Degree or title) <u>Paul A. Siders, M.D.</u> | | 22b. ADDRESS <u>Cuba, Mo.</u> | | 22c. DATE SIGNED <u>7-24-59</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>7-25-1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Hickcreek Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Cuba, Mo.</u> | |

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| 24. FUNERAL DIRECTOR <u>Paul C. Hamilton, Cuba, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>July 24, 1959</u> | | 26. REGISTRAR'S SIGNATURE <u>Madeline R. Stoll</u> | |
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(Licensed Embalmers' Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

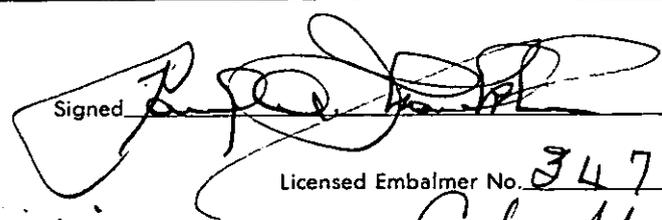
BY AFFIDAVIT OF

AUG 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3472
P. O. Address City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.