

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS NOV 20 1959**

**59-042329**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **210447** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>		Length of stay in lb <b>14 Years</b>		c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2711 Dayton St.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2711 Dayton St</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <b>Ora</b> Middle <b>Lee</b> Last <b>ORONS</b>				4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>1959</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>NEGRO</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10-10-1904</b>		9. AGE (last birthday) <b>55</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory &amp; Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>Columbia Miss</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S. &amp; F.</b>					
13a. FATHER'S NAME <b>SAMON RUSH</b>				13b. MOTHER'S MAIDEN NAME <b>Channie Murphy</b>				14. NAME OF HUSBAND OR WIFE <b>JAMES ORONS</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)   (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>429-16-7840</b>		17. INFORMANT <b>JAMES ORONS 2711 Dayton St</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Burchitis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Leukemia</b> DUE TO (b) <b>2044</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>11-4-59</b> <b>1956</b>							
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 _____ a.m. _____ p.m. _____				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 <b>Nov 4</b> to <b>Nov 11</b> and last saw her him alive on <b>Nov 11</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.															
22. SIGNATURE (Degree or title) <b>J. T. Aldrich MD</b>								22b. ADDRESS <b>2625 Franklin Ave</b>				22c. DATE SIGNED <b>11-14-59</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-16-1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>				23d. LOCATION (City, town, or county) (State) <b>St Louis County</b>							
24. FUNERAL DIRECTOR <b>John W. Broom Garrison</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 13 1959</b>		26. REGISTRAR'S SIGNATURE <b>Loal Smith, M.D.</b>									

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*MJC*

**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 Malace R. Williams

Licensed Embalmer No. 4926

5135 Latus  
P. O. Address \_\_\_\_\_

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.