

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

5371 -60-038499

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 80 Yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3819 Flora		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3819 Flora Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First CATHERINE Middle SELBY Last ORR			4. DATE OF DEATH Month Oct. Day 23, Year 1960	
---	--	--	---	--

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1872	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-------------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) New Martinsville, W. Va.	12. CITIZEN OF WHAT COUNTRY U. S. A.
---	-----------------------------------	---	--

13a. FATHER'S NAME George E. Rider	13b. MOTHER'S MAIDEN NAME Julia F. Martin	14. NAME OF HUSBAND OR WIFE Robert B. Orr
--	---	---

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. 493-26-1262 B	17. INFORMANT Eleanor Catherine Orr	Address Kansas City, Mo.
---	---	---	------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arterio-sclerosis DUE TO (c) 10 year		INTERVAL BETWEEN ONSET AND DEATH 7 day
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"/> N <input type="checkbox"/> Unknown

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 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 April, 1951 and last saw her Oct. 23, 1960 alive on Oct. 22, 1960 Death occurred at 358 A on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE Kenneth A. Davis M.D. (Degree or title)	22b. ADDRESS 201 Plaza Theater Bldg Kansas City, Mo	22c. DATE SIGNED 10-24-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-25-60	23c. NAME OF CEMETERY OR CREMATORY Memorial Park
23d. LOCATION (City, town, or county) Kansas City, Mo.		

24. FUNERAL DIRECTOR Freeman Mortuary	ADDRESS Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 10-25-60	26. REGISTRAR'S SIGNATURE H-L-Dwyer
---	------------------------------------	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **Kenneth A. Davis**

To Kenneth Davis

W. L. V. 201

601-1104

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 *J. S. Freeman*

Licensed Embalmer No. 293

P. O. Address *F. O. 24*

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.