SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-041710
STATE FILE NUMBER

AMENDED

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 31

FILED NOV 20 1961

1. PLACE OF DEATH
a. COUNTY: Maries
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Jackson Twp.
Length of stay in 1b: 20yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION:
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Maries
c. CITY OR TOWN: Vienna, Mo.
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Dixon Route
Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Samuel Middle: Louis Last: Orr

4. DATE OF DEATH: Month: Nov. Day: 15, Year: 1961.

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10/19/1877
9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months: 0 Days: 26
IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (City and state or country): Missouri.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: William Orr
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Arzella Orr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Robert Orr, Address: Vienna, Mo.

MEDICAL CERTIFICATION

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 hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis — unknown
DUE TO (c):
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 Nov 15, 1961, to _____ and last saw him alive on Nov 15, 1961
Death occurred at 8:15p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Manley Gates (Degree or title): D.O.
22b. ADDRESS: Dixon, Mo.
22c. DATE SIGNED: 11-17-'61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11/17/61
23c. NAME OF CEMETERY OR CREMATORY: Vienna Cemetery
23d. LOCATION (City, town, or county) (State): Vienna, Mo.

24. FUNERAL DIRECTOR: M. C. Cunningham ADDRESS: Vienna, Mo.
25. DATE RECD. BY LOCAL REG.: Nov. 17-1961
26. REGISTRAR'S SIGNATURE: Mozelle Hutchison

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3664

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.