

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011267

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 476

FILED APR 3 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY OZARK	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 1 MO.	c. CITY OR TOWN TRAIL
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) TRAIL MO.
3. NAME OF DECEASED (Type or print) First MISSOURI Middle B. Last ORWICK			4. DATE OF DEATH Month MARCH Day 28 Year 1963
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 FEB. 11 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 75
11a. FATHER'S NAME C.C. HALL		11b. MOTHER'S MAIDEN NAME ELIZA FOSTER	11c. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO		12b. SOCIAL SECURITY NO.	12c. IF UNDER 24 HR Months 75 Days 75 Hours 75 Min. 75
13a. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal		13b. NAME OF HUSBAND OR WIFE WILLIAM D. ORWICK (DEC	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis with		14. NAME OF HUSBAND OR WIFE WILLIAM D. ORWICK (DEC	
DUE TO (c) cerebral thrombosis.		15. BIRTHPLACE (City and state or country) TRAIL MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		16. CITIZEN OF WHAT COUNTRY U.S.A.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. INFORMANT MRS. EVELYN WHITE SPRINGFIELD, MO	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		18. INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		19. ADDRESS RT # 5	
20c. TIME OF INJURY. Hour 3:40 P.M. Month, Day, Year 28 Feb 1963		20. NAME OF HUSBAND OR WIFE WILLIAM D. ORWICK (DEC	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21. I attended the deceased from 28 Feb 1963 to 28 Mar 1963 and last saw her/him alive on 28 Mar 1963	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22. DATE SIGNED 29 Mar 63	
20f. CITY, TOWN, OR LOCATION TRAIL MO.		23. SIGNATURE Samuel E. Holmes M.D.	
21. I attended the deceased from 28 Feb 1963 to 28 Mar 1963 and last saw her/him alive on 28 Mar 1963		24. ADDRESS 600 S. Glenstone, Springfield	
22. SIGNATURE Samuel E. Holmes M.D.		25. DATE RECD. BY LOCAL REG. April 4 1963	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		26. REGISTRAR'S SIGNATURE Effie S. Melton	
23b. DATE 3/31/63		27. NAME OF CEMETERY OR CREMATORY EATON CEMETERY	
23c. NAME OF CEMETERY OR CREMATORY EATON CEMETERY		28. LOCATION (City, town, or county) TRAIL, MO.	
24. FUNERAL DIRECTOR H.H. LOHMEYER FUNERAL HOME		29. ADDRESS SPRINGFIELD, MO.	

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

Lucian J. Swadlow

Licensed Embalmer No. 4875

P. O. Address Springfield, 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.