DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 10 1946

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 10482

Registration District No. 296 — Primary Registration District No. 6019 — Registrar's No. 11

**1. PLACE OF DEATH:**
(a) County Ray
(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2½ miles South East of Orrick (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 60 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Ray 89
(c) City or town Rural 0 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) Citizen of foreign country? No 0 (Yes or No)
If yes, name country ____

**3. (a) PRINT FULL NAME** HETTIE G. DORTON
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex Female | 5. Color or race White | 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William R Dorton 6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased March (Month) 7 (Day) 1874 (Year)

8. AGE: Years 71 | Months 11 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation Housekeeper 9
11. Industry or business ____

MOTHER FATHER
12. Name William Wilson
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Joan Oglin
15. Birthplace Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Wm R Dorton
(b) Address Route-2- Orrick, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 3 46 (Month) (Day) (Year)
(c) Place: burial or cremation South Point
18. (a) Signature of funeral director B. W. Good
(b) Address Orrick Mo.
19. (a) 3/2-46 (Date received local registrar) (b) Helen J Larkin (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st year 1946 hour 12 minute 50 P.M.
21. I hereby certify that I attended the deceased from Jan. 1 1945 to Dec. 11 1945 that I last saw her alive on Dec. 11 1945 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Acute Myocarditis | Unknown |
| Due to Contributory Decomposition | 1 year |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings: Of operations 9 3 0 Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place) While at work? (e) Means of injury ____

23. Signature Fred E Shultz (M. D. or other)
Address Orrick Mo. Date signed 3-2-46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number .....

Date Filed 4-9-46

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**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 Self, Registered Apprentice No. ....., working under my personal supervision.

Signed Victor E. Armiger

Licensed Embalmer No. 2896

P. O. Address Liberty, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE
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# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 296 Primary Registration District No. 6019 Registrar's No. 11

**1. PLACE OF DEATH:**

(a) County Ray Rural

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2½ Mi. S.E. ORRICK. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)

In this community 60 YRS. years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Hettie L. Horton

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May 4 (Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER / FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

10482