

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31462

BIRTH NO. 296 REG. DIST. NO. 296 PRIMARY REG. DIST. NO. 6019 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Ray	
b. CITY OR TOWN Rural--Orriok		c. CITY OR TOWN Rural Orriok	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Russell	c. (Last) Dorton	4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 49
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 5, 1871	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MINS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME J. W. Dorton	13b. MOTHER'S MAIDEN NAME Mary Good	14. NAME OF HUSBAND OR WIFE Hettie Dorton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME J. G. Dorton	ADDRESS Orriok, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 day
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		f501	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) - (COUNTY) - (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **9-2-**, 19**49**, to **9-3-**, 19**49**, that I last saw the deceased alive on **9-3-**, 19**49**, and that death occurred at **7:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Vinyl E. Shale M.D.	23b. ADDRESS Orriok Mo.	23c. DATE SIGNED 9-3-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 5, 49	24c. NAME OF CEMETERY OR CREMATORY South Point	24d. LOCATION (City, town, or county) (State) Orriok, Mo.
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DATE REC'D BY LOCAL REG. 9-5-49	REGISTRAR'S SIGNATURE Helen J. Larkin	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Good	ADDRESS Orriok, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED SEP 8
District Health Officer No. 8,
District File Number _____
Date Recd. 9-22-49

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.

Signed _____
Student Embalmer

Signed James C. Wallace
Licensed Embalmer No. 3921

P. O. Address 3803 Main
K.C. 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 this body is not embalmed, fact should be so stated above.