

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

18 736349

1. PLACE OF DEATH

County Lackam Registration District No. _____
 Township St. Mary Primary Registration District No. _____
 City K.C. Mo. (No. 220 Wabash) St. _____ Ward _____

File No. _____
 Registered No. 1750
 St. _____ Ward _____

2. FULL NAME

Patrick Charles O'Dell
 (a) Residence. No. 220 Wabash St. 9 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr - 18 - 1916

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
14 7 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boy
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Michigan

10. NAME OF FATHER Chas. O. Dell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Michigan

12. MAIDEN NAME OF MOTHER Kathleen Muller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

14. INFORMANT Chas. O. Dell

(Address) 220 Wabash

15. FILED 11/24/30 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov - 23 - 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS

Accidental drowning
18³⁰ P
found dead in (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Systemic sclerosis K.C. Mo. (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) John Carbaugh, D.
73, 1930 (Address) Cerever

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Marys Ceme DATE OF BURIAL Nov 25 1930

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

