

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

Do not use this space.

1. PLACE OF DEATH **Veterans' Administration Hospital, 301**

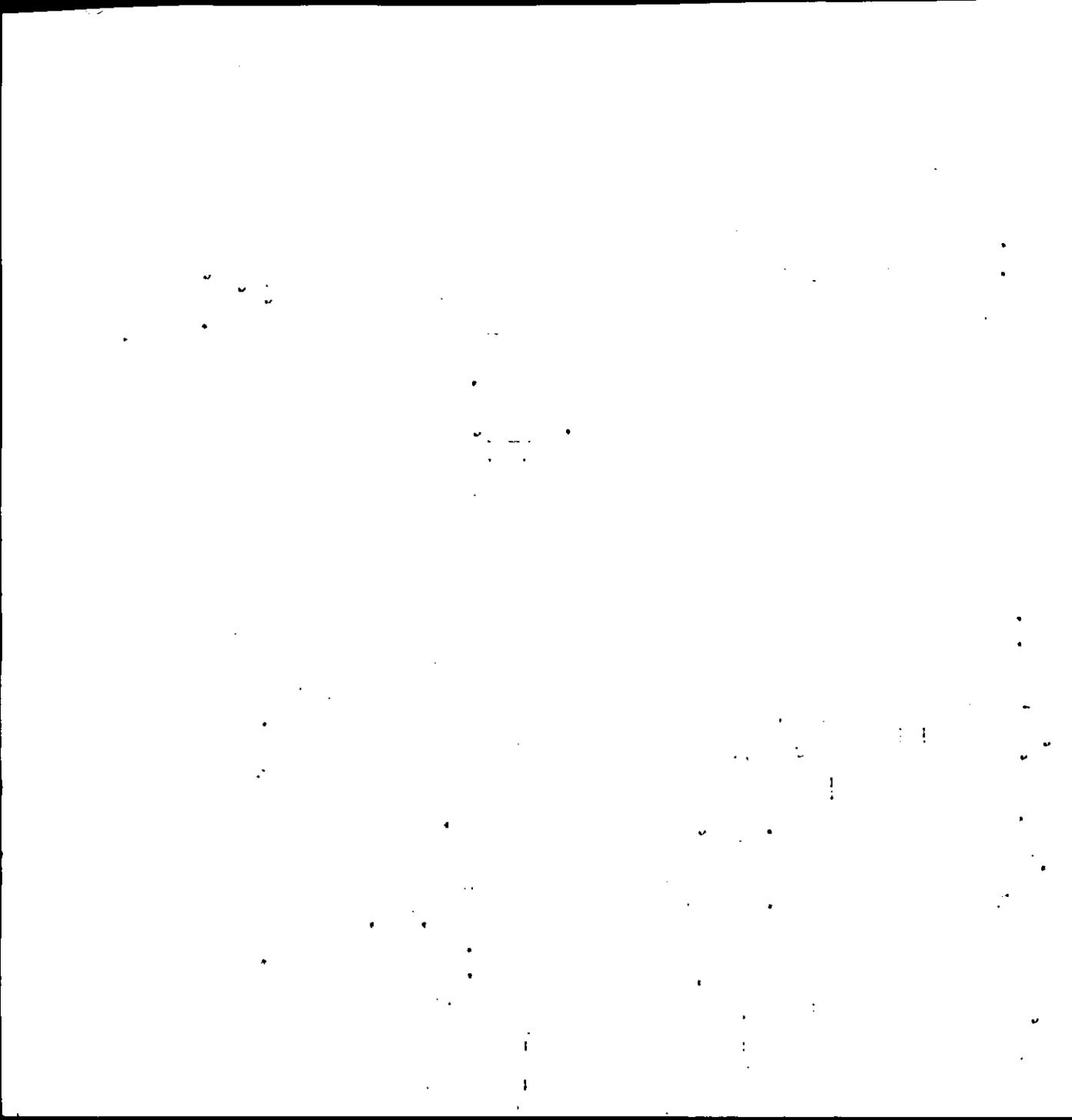
31423

County **Jackson** Registration District No. _____
 Township **Law** Primary Registration District No. _____
 City **Kansas City, Mo.** (No. **4. B. Veterans' Hospital**) St. _____ Registered No. **3921** Ward) _____

2. FULL NAME **HARRAL, Odus Reed** C-None WOE
 (a) Residence, No. **Cabool, Missouri** St. **Mo.** **Pvt. 1/c Co D 31st Inf.**
 (Usual place of abode) **Rt 2** (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) Aug. 30, 1887				
7. AGE	YEARS 44	MONTHS 0	DAYS 23	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farming.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____			
	10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri				
FATHER	13. NAME Unknown			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown			
MOTHER	15. MAIDEN NAME Unknown			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown			
17. INFORMANT Hospital Records (ADDRESS) _____				
18. BURIAL, CREMATION, OR REMOVAL PLACE Nat'l Military Home, Kansas DATE 9-24-31				
19. UNDERTAKER Freeman Mortuary (ADDRESS) K.C., Mo				
20. FILED 9-23-31 M. M. Browne Registrar				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 23	19 31
22. I HEREBY CERTIFY, That I attended deceased from August 15 , 19 31 to Sept. 23 , 19 31 I last saw h im alive on Sept. 23 , 19 31 Death is said to have occurred on the date stated above, at 6:00 A.M. The principal cause of death and related causes of importance were as follows: Septic Infection <i>(non-contagious)</i> 101 36 2/6 Other contributory causes of importance: Operation and removal of infected inguinal lymph glands, right side. Inguinal Adenectomy Date of 9-5-31 Name of operation _____ Date of _____ What test confirmed diagnosis? Phys. Exam. Was there an autopsy? Yes	
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury _____, 19 _____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. _____ Manner of injury _____ Nature of injury _____	
24. Was disease or injury in any way related to occupation of deceased? No If so, specify _____ (Signed) W. E. Chambers M. D. W. E. CHAMBERS, Med. Officer in Charge. Veterans' Administration Hospital, Kansas City, Missouri.	



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. 3921
 City St. Louis (No. U.S. Veterans Hospital) Ward _____

2. FULL NAME

Odeus Reed Howard
 (a) Residence. No. _____ St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

PARENTS

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14.

INFORMANT _____
 (Address) _____

15.

FILED 9/23/31 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 25 1931

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:
Septic Infection
non-contagious

CONTRIBUTORY (duration) _____ yrs. _____ mos. _____ da.
 SECONDARY Chronic inflammation of prostate
glands (suppurative) (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 _____, 19____ (Address) _____

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-31423