

REC'D JAN 5 1940

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

42101  
Do not use this space.

1. PLACE OF DEATH

(a) County Carter Registration District No. 749-146  
(b) Township Pike Primary Registration District No. 5-205 5 366 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ or \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Peggy Yvonne Odam  
Carter County

(a) Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-9-39  
7. AGE YEARS 1 MONTHS 9 DAYS 11 IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-20-1940  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 2 P.M.  
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Date of onset \_\_\_\_\_  
Diphtheria  
Other contributory causes of importance: 10

12. BIRTHPLACE (CITY OR TOWN) Garberville  
(STATE OR COUNTRY) Calif.

13. NAME William Odam /  
(STATE OR COUNTRY) Unionville Mo. D

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
(STATE OR COUNTRY) \_\_\_\_\_ D

15. MAIDEN NAME Dorothy Dickerson

16. BIRTHPLACE (CITY OR TOWN) Low Wassie  
(STATE OR COUNTRY) Mo.

17. INFORMANT Wm. Odam  
(ADDRESS) Carter County

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Zion Cem. DATE 11-21-40

19. FUNERAL DIRECTOR (NAME) None  
(ADDRESS) \_\_\_\_\_

20. FILED 11-20-1940 J. N. Coonan  
Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no  
23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ 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. Mo.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? 5  
If so, specify Phis. A. Leche, Carone  
(Signed) \_\_\_\_\_ M. D.  
(Address) Van Buren Mo.

(Licensed Embalmer's Statement on Reverse Side)

no physician

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.

RECEIVED

District Health Officer No. 5,

District File Number 12461174

Date Filed \_\_\_\_\_

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision. /

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

**If this body is not embalmed, above space should be left blank.**