DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 19 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3337

Registration District No. 743 | Primary Registration District No. 6237 | Registrar's No. 2

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: RAY, Fishing River 5
(b) City or town: Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Seven Miles South East Ex Sp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: no (Specify whether years, months or days) In this community: 81 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Ray 81
(c) City or town: 7 Mi. S. E. Ex. Sp. 8 (If outside city or town limits, write "RURAL")
(d) Street No.: Rural 0 (If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME: Wm G. O'DELL
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: male
5. Color or race: white
6. (a) Single, widowed, married, divorced: widowed
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: no years
7. Birth date of deceased: March (Month) 24 (Day), 1860 (Year)

8. AGE: Years	Months	Days	If less than one day
81	10	8	hr. min.

9. Birthplace: Ray Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Caleb O'Dell
13. Birthplace: unknown (City, town, or county) Ray Co. (State or foreign country)
MOTHER 14. Maiden name: Sarah O'Dell
15. Birthplace: unknown (City, town, or county) Ray Co. (State or foreign country)
16. (a) Informant: Ray O'Dell
(b) Address: La Monte, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/3/42 (Month) (Day) (Year)
(c) Place: burial or cremation: Pisgah Cemetery
18. (a) Signature of funeral director: Herbert Hope
(b) Address: Excelsior Springs
19. (a) 2-5-42 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2 year 42 hour 6 minute 45 A. M.
21. I hereby certify that I attended the deceased from Jan 25-1942 to ~~Feb 2 1942~~ Feb 2 1942 that I last saw him alive on Feb 1 1942 and that death occurred on the date and hour stated above.
Immediate cause of death: Uremia ✓ — Duration: 4 or 5 days
Due to: Sec. arteria sclerosis — Duration: 1 mo to date Jan 25-42
Due to:
Other conditions: — (Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: none

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: 0
23. Signature: G. D. Craven (M. D. or other)
Address: Excelsior Spgs. Mo Date signed: 2-2-42

(Licensed Embalmer's Statement on Reverse Side)

...EIVED
... Health Officer No. 8,
...ict File Number.....
Date Filed 2-17-42

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 Scott W. Freckmann

Licensed Embalmer No. 3597

P. O. Address Galion Springs Ohio

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.

. S No. 2B
0M—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3337

Registration District No. 743 Primary Registration District No. 6237 Registrar's No.

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:
(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

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: Wm. G. O'Dell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife

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

7. Birth date of deceased: Mar (Month) 24 (Day) 1860 (Year)

8. AGE: Years 81 Months 10 Days If less than one day hr. min.

9. Birthplace (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)

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 him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
America	
Due to with slight Dermatitis	
Due to General arteriosclerosis & nephritis	
Other conditions (Include pregnancy within 3 months of death) Had slight stroke about 1 wk before	
Major findings: Of operation death	
Of autopsy 12 hr	

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)

(b) 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

SUPPLEMENTARY