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

ARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 13 1943

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

2898

State File No.

Registration District No. 233 Primary Registration District No. 4348 Registrar's No. 26

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Wellsville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution — (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Montgomery 70 2 0
(c) City or town Wellsville
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME ELIZABETH, ALACE OGGEN
3. (b) If veteran, name war —
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Benjamin F Odgen
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Sept (Month) 24 (Day) 1856 (Year)

8. AGE: Years 86 Months 3 Days 24 If less than one day — hr. — min.

9. Birthplace Audrain Co (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation House wife
11. Industry or business —
FATHER
12. Name James Fields
13. Birthplace Not Known (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Francis Boswell
15. Birthplace Not Known (City, town, or county) 9 (State or foreign country)
16. (a) Informant Reta Hildebrand
(b) Address Wellsville Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan (Month) 22 (Day) 1943 (Year)
(c) Place: burial or cremation Wellsville Mo
18. (a) Signature of funeral director F. O. Kuhne
(b) Address Wellsville Mo
19. (a) Jan 25 1943 (Date received local registrar) (b) Mrs Virgie Norton (Registrar's signature)

1043

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 19
year 1943 hour 600 minute P.M.
21. I hereby certify that I attended the deceased from Jan 1, 1943, to Jan 19, 1943
that I last saw her alive on Jan 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Poison,
Due to dislocation of right shoulder,
Due to Myocarditis,
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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) 070
(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
23. Signature W. H. Walls (M. D. or other) DO
Address Wellsville Date signed 1/25/43

(Licensed Embalmer's Statement on Reverse Side)

## 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. 3059

P. O. Address Wellsville

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

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
M—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. 2898

Registration District No. 233 Primary Registration District No. 4348 Registrar's No. 26

SUPPLEMENTARY

**1. PLACE OF DEATH:**

(a) County Montgomery

(b) City or town Wellsville
(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
In this community years, months or days)

**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 Elizabeth Alace Odgen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wd

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 24 (Day) 1857 (Year)

8. AGE: Years 86 Months 3 Days 24 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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)

MOTHER
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 Jan day 18
year 1943 hour 4:00 minute P.M.

21. I hereby certify that I attended the deceased from Sept 16 1942 to Jan 19 1943
that I last saw him alive on Jan 19 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremic Poison — Duration 1/19/1943

Due to dislocation of right shoulder — 3 Day

Due to Myocarditis — 6 years

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 195 e'

Of autopsy 99

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) dislocation of

(b) Date of occurrence Jan 16 left shoulder

(c) Where did injury occur? Wellsville (City or town) Montgomery (County) Mo (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?
home, how do not know
(Specify type of place)

While at work? in night (e) Means of injury

23. Signature Willis H. Walls (M. D. or other) D.O.

Address Wellsville Date signed 8/2/43