DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 22248

Registration District No. 297 — Primary Registration District No. 6022 — Registrar's No. 39

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

1. PLACE OF DEATH:
(a) County Ray
(b) City or town Richmond-Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Richmond Twp 1 (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 Missouri (b) County Ray
(c) City or town Richmond RURAL 09 (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location) 0
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Clyde Wendle O'dell
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced 6
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Feb (Month) 21 (Day) 1937 (Year)

8. AGE: Years 6 Months 3 Days 23 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) 9 (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER
12. Name Clyde O'Dell
13. Birthplace Ray Co (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name Ollie Lebold
15. Birthplace Ray Co (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Clyde O'Dell
(b) Address Richmond Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-16-43 (Month) (Day) (Year)
(c) Place: burial or cremation Hickory Grove Cemetery
18. (a) Signature of funeral director John W. Kreipschild
(b) Address Holden Mo.
19. (a) June 15-43 (Date received local registrar) (b) Mrs Chas W. Sheppard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1943 hour 7 minute 30 P. M.
21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....; that I last saw h..... alive on ....., 19....; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Drowning | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) — | |
| Major findings: Of operations — | |
| Of autopsy — | |

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) accident
(b) Date of occurrence June 14, 1943
(c) Where did injury occur? Richmond, Rural (City or town) Ray (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm (Specify type of place)
While at work? no (e) Means of injury Drowning
23. Signature J. F. Baber (M. D. or other) Coroner
Address Richmond Mo Date signed 6.15.43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-13-43

**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 me, Registered Apprentice No. working under my personal supervision.

Signed John W. Knipschild
Licensed Embalmer No. 2789
P. O. Address Hardin Mo

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

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

. No. 2B
M—5-43
I X36930

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THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 297 Primary Registration District No. Registrar's No.

**1. PLACE OF DEATH:**

(a) County Ray

(b) City or town
(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 Clyde Wendle Odell

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 21 1933
(Month) (Day) (Year)

8. AGE: Years 6 Months 3 Days If less than one day hr. min.

9. Birthplace Richmond Mo Ray Co, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

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 June day 4 year 43 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from ..., 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 |
|---|---|
| | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

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

5-22248