

No. 12
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 30 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38488
Registrar's No.

Registration District No. 262

Primary Registration District No. 5882

1. PLACE OF DEATH: Ozark
(a) County
(b) City or town Rural Bayon Twp.
(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. 1
In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Ozark 77
(c) City or town Rural, Bayon Twp.
(If outside city or town limits, write "RURAL")
(d) Street No. J
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME Martha Pearl Adell
3. (b) If veteran, name war
3. (c) Social Security No.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 19
year 1944 hour 8 minute 50 a.m.
21. I hereby certify that I attended the deceased from occasionally
Jan 1944 to Oct 19 1944
that I last saw her alive on Oct 18 1944
and that death occurred on the date and hour stated above.

4. Sex fem. 5. Color or race. 6. (a) Single, widowed, married, divorced. married
6. (b) Name of husband or wife. none. 6. (c) Age of husband or wife if alive. 75 years
7. Birth date of deceased. Dec 25 1874
(Month) (Day) (Year)

Immediate cause of death
Interstitial nephritis 1 yr
Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

8. AGE: 69 Years Months 9 Days 19
If less than one day hr. min.

PHYSICIAN
Major findings:
Of operations
Of autopsy
Underline the cause to which death should be charged statistically.

9. Birthplace Ozark Co Mo. (City, town, or county) (State or foreign country)
10. Usual occupation house wife

MOTHER FATHER
11. Industry or business
12. Name Bud Taylor
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name James
15. Birthplace (City, town, or county) (State or foreign country)

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?
While at work? (Specify type of place) (e) Means of injury
23. Signature J.A. Beach M.D. (M. D. or other)
Address Elijah, Mo Date signed 10-19-44

16. (a) Informant Emory Adell
(b) Address Elijah, Mo
17. (a) Burial (b) Date thereof Oct 20 '44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Elijah, Mo
18. (a) Signature of funeral director by friends
(b) Address Elijah, Mo
19. (a) Oct 19-44 (b) J.A. Beach
(Date received local registrar) (Registrar's signature)

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

203
4-44

DEC 12 1944

DEC 1 1944

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 comply with the above constitutes grounds for revocation of license.)

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38488

Registration District No. 262

Primary Registration District No. 5887

Registrar's No. _____

1. PLACE OF DEATH:

(a) County gosh
 (b) City or town Rural Barton
(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)

3. (a) PRINT FULL NAME Martha Pearl Odell

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 m

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

7. Birth date of deceased Dec 25
(Month) (Day) (Year)

8. AGE: 69 Years 9 Months 1 Day me
If less than one day hr. min.

9. Birthplace gosh
(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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County gosh
 (c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Oct Day 19 Year 1944 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 _____

Chronic nephritis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

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

Duration _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

