

FILED JAN 19 1945
Registration District No. _____

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:

(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
400 S MADISON
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community ALWAYS
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53
(c) City or town LEBANON
(If outside city or town limits, write "RURAL")
(d) Street No. 400 S. MADISON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ARTELIA ELLEN O'DELL

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 WIDOW
(b) Name of husband or wife SOLOMON O'DELL 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased SEPT 6 1856
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
88 3 12 hr. min.

9. Birthplace WRIGHT CO MO IN
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER
12. Name CLEVELAND HAGGARD
13. Birthplace TENN
(City, town, or county) (State or foreign country)
14. Maiden name ANN MARY LORANCE
15. Birthplace TENN
(City, town, or county) (State or foreign country)

16. (a) Informant R.C. O'Dell
(b) Address LEBANON MO

17. (a) BURIAL (b) Date thereof 12-20-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation BAIR THICKET

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO

19. (a) 12-29-44 (b) Grace Roper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 18TH
year 1944 hour 8 minute 45 A.M.
21. I hereby certify that I attended the deceased from Dec 10 1944 to Dec 17 1944
that I last saw him alive on Dec 17 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Bronchitis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 10 11

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: NO
(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 J. L. Bennage (M. D. or other)
Address Lebanon Mo. Date signed 12-29-44

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

Received

Laclade County Health Unit

File No. 12-44-173

Date Filed 1/18/45

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 *Allyn Dethridge Hooker*

Licensed Embalmer No. 4323

P. O. Address *Libanon 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.