. No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

28623

State File No.

FILED SEP 12 1945

Registration District No. 324 Primary Registration District No. 3082 Registrar's No. 118

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Fitzgibbons Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 80 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97

(c) City or town Napton, R.F.D.
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Olive Elizabeth Odell

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife James M. Odell

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

7. Birth date of deceased July 16th, 1858
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
87	0	15	hr. min.

9. Birthplace Nodaway county Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Stephen Jester
13. Birthplace — ILL.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Betty Saunders
15. Birthplace Louisville Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Odell
(b) Address Napton, Mo. R.F.D.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 2, 1945
(Month) (Day) (Year)

(c) Place: burial or cremation Ridge Park cemetery

18. (a) Signature of funeral director [illegible]
(b) Address Marshall, Missouri

19. (a) Aug. 17. 1945 (Date received local registrar) (b) Mrs T. Oubetbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from July 29, 1945 to July 31, 1945
that I last saw her alive on July 29, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	7 days
Due to	
Due Arterial Sclerosis	4 yrs
Other conditions Fracture Rt Hip	7 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 97

(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 [illegible] (M.D. or other)

Address Marshall Mo Date signed 8/1/45

1215

(Licensed Embalmer's Statement on Reverse Side) S.P. Simmons

RECEIVED
District Health Officer No. 8.
District File Number
Date Filed 9-8-45

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 R. W. Campbell Jr.

Licensed Embalmer No. 3489

P. O. Address Marshall, 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.

S. No. 2B
25M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 118

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(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 Aline E. 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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 16 1880 (Month) (Day) (Year)

8. AGE: Years 87 Months 9 Days 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
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 July 1, year 1945 (hour) minute M.
21. I hereby certify that I attended the deceased from 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
Due to
Due to 1860's 14
Other conditions Blind
(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) Fall in her room
(b) Date of occurrence July 26-45
(c) Where did injury occur? Her Home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? (e) Means of injury Fall
23. Signature (M. D. or other)
Address Marshall Date signed 9/4/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

S- 28623