

S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 22 1947

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1846

Registration District No. 217

Primary Registration District No. 3045

State File No.

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Mississippi
(b) City or town CHARLESTON, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
312 CLEVELAND ST.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community 11 YRS.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi
(c) City or town Charleston, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 312 Cleveland St.
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ANNA ODOM

3. (b) If veteran, name war 3. (c) Social Security No. NONE

4. Sex F 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife JIM ODOM dead 6. (c) Age of husband or wife if alive years

7. Birth date of deceased: A. PRI. 8 1861
(Month) (Day) (Year)

8. AGE: Years 86 Months 86 Days 10 9 If less than one day hr. min.

9. Birthplace: Greene KY
(City, town, or county) (State of

10. Usual occupation Housekeeper

11. Industry or business

12. Name P. JIM SMITH

13. Birthplace Unknown KY
(City, town, or county) (State of

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fred Long

(b) Address 312 Cleveland St. Charleston

17. (a) Removal (b) Date thereof 1-17-47
(Date, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olive, Mayfield Ky

18. (a) Signature of funeral director Wm. B. Shonk

(b) Address Charleston, Mo.

19. (a) 1-17-47 (b) Mrs. John Bondurant
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17
year 1947 hour Eighth minute 22 A.M.

21. I hereby certify that I attended the deceased from Jan 12 1947 to Jan 17 1947
that I last saw her alive on Jan 16 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Duration 6 days

Due to Senility
senile dementia 5 wks

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy 107

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?

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

23. Signature W. P. Fenton (M.D. or other) W.D.
Address Wyatt, Mo. Date signed 1-17-47

(Licensed Embalmer's Statement on Reverse Side)

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

1
2

196

RECEIVED

District Health Office No. 2,

District File Number 147-97

Date Filed 1-20-47

Mrs. Anna Odum, was not embalmed.

W. R. Linton Jr. Funeral Dir.

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.