

FILED JAN 12 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

575

State File No.

BIRTH NO. _____ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 5291 Registrar's No. 2

024

1. PLACE OF DEATH
a. COUNTY Clay
b. CITY (If outside corporate limits, write RURAL and give townships) OR TOWN Rural Liberty
c. LENGTH OF STAY (in this place) 6 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION Clay County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Clay
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Excelsior Springs
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED
a. (First) Ida
b. (Middle) Belle
c. (Last) O'Dell

4. DATE OF DEATH
(Month) JAN (Day) 5 (Year) 1950
Feb. 5 - 14 - 1866

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH Feb. 14 - 1866
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR (Months) 10 IF UNDER 12 HRS. (Hours) 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? US.

13a. FATHER'S NAME George Cook
13b. MOTHER'S MAIDEN NAME Nancy Samuels
14. NAME OF HUSBAND OR WIFE Jim O'Dell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NO
17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Louanna Samuels Excelsior Spgs Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH 2 years.
ANTECEDENT CAUSES
MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
4500

19a. DATE OF OPERATION _____
19b. MAJOR FINDINGS OF OPERATION _____
20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Nov, 1949, to Jan, 1950, that I last saw the deceased alive on Dec 15, 1949 and that death occurred at 12:15 P., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wm. J. Goodson MD
23b. ADDRESS Liberty Mo.
23c. DATE SIGNED JAN 5 - 1950

24a. BURIAL, CREMATION REMOVAL (Specify) Burial
24b. DATE Jan. 7 - 1950
24c. NAME OF CEMETERY OR CREMATORY Crown Hill
24d. LOCATION (City, town, or county) (State) Excelsior Springs, Mo.

DATE REC'D BY LOCAL REG. JAN 7, 1950
REGISTRAR'S SIGNATURE Dominic Haynes
64
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Church-Creen Co. Liberty Mo

WRITE PLAINLY--USING UNFADING BLACK-INK--MAKE A PERMANENT RECORD

RECEIVED JAN 9

District Health Officer No. R,

District File Number.....

Date Filed 1-11-58

MAR 8 1958

JAN 8 1961

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed John Embalmer.....
Licensed Embalmer No. 4448

P. O. Address Liberty 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.