

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30299**
Registrar's No. **7459**

FILED AUG 20 1953

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 30299		Registrar's No. 7459																	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____																					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY in this place 2 weeks		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John, s Hosp.				STREET ADDRESS (If rural, give location) 16 3847 Giles																					
3. NAME OF DECEASED (Type or Print) a. (First) Nora			b. (Middle) _____			c. (Last) ODIEN			4. DATE OF DEATH (Month) (Day) (Year) 7-30 -1953																
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 11-25-1878		9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months 8 Days 5		IF UNDER 2 HRS. Hours _____ Min. _____													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (City and State or Foreign Country) Ireland 4				12. CITIZEN OF WHAT COUNTRY? USA															
13a. FATHER'S NAME John Barrett				13b. MOTHER'S MAIDEN NAME Cathrine Connell				14. NAME OF HUSBAND OR WIFE Richard Odien																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give dates of service) No None				16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Richard Odien 3847 Giles																			
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.												MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) carcinomatosis ANTECEDENT CAUSES DUE TO (b) old age DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none												INTERVAL BETWEEN ONSET AND DEATH middle of June - or early July until present time	
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>													
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) _____			21d. (COUNTY) _____			21e. (STATE) _____													
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? 170X																	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7/30 , 19 53 , and that death occurred at 2 P. M. , from the causes and on the date stated above.																									
23a. SIGNATURE (Degree or title) Chas Hugh Nelson M.D.								23b. ADDRESS Humboldt Bldg				23c. DATE SIGNED 7/31/53													
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial			24b. DATE 8-1-1953		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			24d. LOCATION (City, town, or county) (State) St. Louis Mo																	
DATE REC'D BY LOCAL REG. JUL 31 1953			REGISTRAR'S SIGNATURE J. Carl Smith				25. FUNERAL DIRECTOR'S SIGNATURE WINGBERMUEHLE				ADDRESS 3819 S Grand Blvd														

(Licensed Embalmer's Statement on Reverse Side)

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

Probability of present was primary

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 467

P. O. Address St. Louis 18

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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