

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7009

State File No. 1053
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) ST. LOUIS | c. LENGTH OF STAY (in this place) 8 HRS. | c. CITY OR TOWN WEST FRANKFORT | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S HOSPITAL | | e. STREET ADDRESS (If rural, give location) 310 S. ODLE 8128 | |

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|--|---------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) RICHARD b. (Middle) KEITH c. (Last) ODLE | | | 4. DATE OF DEATH (Month) (Day) (Year) 1 - 29 - '56 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 12-16-55 | 9. AGE (In years last birthday) | 10. MONTH (Day) (Year) of UNDER 1 YEAR 1-13 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) ILLINOIS | 12. CITIZEN OF WHAT COUNTRY? U.S. |

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| 13a. FATHER'S NAME CECIL G. ODLE | 13b. MOTHER'S MAIDEN NAME LOIS MILLIGAN | 14. NAME OF HUSBAND OR WIFE |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. - | 17. INFORMANT'S SIGNATURE OR NAME V. TODD | ADDRESS 500 S. KINGSHIGHWAY |
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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC DECOMPENSATION | | 6 WKS |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CONGENITAL HEART DISEASE DUE TO (c) | | 6 WKS |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (COUNTY) (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? |

22. I hereby certify that I attended the deceased from 1-29, 1956, to 1-29, 1956, that I last saw the deceased alive on 1-29, 1956, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

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| 23a. SIGNATURE V. TODD | (Degree or title) M.D. | 23b. ADDRESS 500 S. KINGSHIGHWAY | 23c. DATE SIGNED JAN 30 1956 |
|---------------------------|---------------------------|-------------------------------------|---------------------------------|

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|---|----------------------|------------------------------------|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE 1-30-56 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) West Frankfort, Ill. |
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| DATE REC'D BY LOCAL REG. JAN 31 1956 | REGISTRAR'S SIGNATURE Carl Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE Walker, West Frankfort, Ill. | ADDRESS |
|---|--|--|---------|

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

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 *Bill C. Brannon*

Licensed Embalmer No. *4769*

P. O. Address *St Louis*

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.