

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-045306  
STATE FILE NUMBER

FILED JAN 6 1959

Registration District No. 316 Primary Registration District No. 3054 Registrar's No. 488

S. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St Francois</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Farminington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>		Length of stay in lb <u>2 wks</u>	d. STREET ADDRESS (If outside, give location) <u>522 Maple</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Ellen</u> Last <u>O'Dell</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>29</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White US</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12, 1888</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>St Francois Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Kirkpatrick</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Day</u>		14. NAME OF HUSBAND OR WIFE <u>Dave C. O'Dell (Deceased)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs Vera Stuart, Farmington, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterine</u> DUE TO (b) <u>Carcinoma endometrium post hysterectomy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>172X</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>Days</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>Oct 1956</u> to <u>Dec 29, 1958</u> and last saw her/him alive on <u>Dec 29, 1958</u> Death occurred at <u>10:00 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>George L. Wason M.D.</u>			22b. ADDRESS <u>Farminington, Mo.</u>		22c. DATE SIGNED <u>1-2-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/1/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Farminington, Mo.</u>
24. FUNERAL DIRECTOR <u>Miller Funeral Home, Farmington, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 3, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>	

JAN 9 1959

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 Paul Dugal

Licensed Embalmer No. 4120

P. O. Address Farmington

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.