

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025336

FILED JUL 17 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER Registrar's No. 3150

S. 300  
-1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Independence</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Length of stay in lb <u>24</u> days	d. STREET ADDRESS (If outside, give location) <u>700 S. 1218 W. 26th.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>D.</u> Last <u>O'Dell</u>			4. DATE OF DEATH Month <u>6</u> Day <u>26</u> Year <u>59</u>		
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1909</u>	9. AGE (In years last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Ray County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>Robert Odell</u>	13b. MOTHER'S MAIDEN NAME <u>Gladys Blair</u>	14. NAME OF HUSBAND OR WIFE <u>none</u>
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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. <u>495-03-5725</u>	17. INFORMANT <u>Mrs. Gladys Odell</u>	Address <u>Richmond, Mo.</u>
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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>Squamous cell carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>metastasis.</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>1919</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour <u>8:05</u> a.m. <u>PM</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>General Hospital</u>	COUNTY <u>Knoxville</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>6-2-59</u> to <u>6-26-59</u> and last saw <u>him</u> alive on <u>6-26-59</u> Death occurred at <u>8:05 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Abraham Galperin</u> (Degree or title) <u>0</u>	22b. ADDRESS <u>General Hospital</u>	22c. DATE SIGNED <u>6-26-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>6-29-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Knoxville Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Knoxville, Mo.</u>
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24. FUNERAL DIRECTOR <u>Wesley Lill, Richmond Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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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.

Abraham Galperin USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by the  
 Doctor, coroner, etc. must use only standard nomenclature in it  
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWR.

MEDICAL CERTIFICATION

Conditions, if any,  
 which gave rise to  
 above cause (a),  
 stating the under-  
 lying cause last.

DUE TO (b) \_\_\_\_\_

DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY  
 PERFORMED?  
 YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY  
 Hour .Month, Day, Year  
 a.m.  
 p.m.

20d. INJURY OCCURRED  
 WHILE AT  NOT WHILE  
 WORK AT WORK

20e. PLACE OF INJURY (e.g., in or about home,  
 farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw <sup>her</sup> alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,  
 REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

*Quest Life Funeral Home  
 Richmond, Missouri An. Denton*

(Licensed Embalmer's Statement on Reverse Side)