

R1 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030959

FILED VS AUG 31 1959

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2283 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		Length of stay in 1b <u>23 DAYS</u>	c. CITY OR TOWN <u>Jennings</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>St. Louis Co Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7306 Jenwood Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EZRA</u> Middle <u>O'DELL</u> Last <u>O'DELL</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1959</u>		
--------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------------	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-4-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
-----------------------	----------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------	-------------------------------------	----------------------------------------------------	--------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
-----------------------------------------------------------------------------------------------------------------	----------------------------------------------------------	-----------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <u>Joseph O'Dell</u>	13b. MOTHER'S MAIDEN NAME <u>Mary C. Walburn</u>	14. NAME OF HUSBAND OR WIFE <u>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. <u>None</u>	17. INFORMANT <u>Grace O'Dell</u>	Address <u>7306 Jenwood Ave.</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>Reticulum Cell Sarcoma of Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>with Metastases</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	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 July 31, 1959 to Aug. 22, 1959 and last saw ^{her}him alive on Aug. 22, 1959
Death occurred at 12:23 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Silvius L. Hunt M.D.</u> (Degree or title)	22b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	22c. DATE SIGNED
-----------------------------------------------------------------	-------------------------------------------------------	------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-25-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery St. Louis Co., Missouri</u>	23d. LOCATION (City, town, or county) (State)
------------------------------------------------------------	-------------------------------	---------------------------------------------------------------------------------------------	-----------------------------------------------

24. FUNERAL DIRECTOR <u>Jos. W. Clark Funeral H. Hodiament</u>	ADDRESS <u>1125</u>	25. DATE RECD. BY LOCAL REG. <u>8-24-59</u>	26. REGISTRAR'S SIGNATURE <u>June M. Murphy M.D.</u>
-------------------------------------------------------------------	------------------------	------------------------------------------------	---------------------------------------------------------

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eaton R. H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.