

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015819
STATE FILE NUMBER

FILED VS MAY 5 1960

157

3028

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 47 yrs	c. CITY OR TOWN Carthage Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 714 Poplar		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 714Z Poplar St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRANK Middle EARNEST Last O'DELL			4. DATE OF DEATH Month April Day 26 Year 1960	
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5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-23-92	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer	10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (City and state or country) Polk Co, Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Mack O'Dell	13b. MOTHER'S MAIDEN NAME Nancy Pratt	14. NAME OF HUSBAND OR WIFE Stella Mayes O'Dell
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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) no	16. SOCIAL SECURITY NO. 440-38-3510A	17. INFORMANT Mrs. F.E. O'Dell, 714 Poplar Address Carthage, Mo
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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:		INTERVAL BETWEEN ONSET AND DEATH instant death
IMMEDIATE CAUSE (a) occlusion Coronary artery	DUE TO (b) Arteriosclerotic Coronary artery	2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) Disease	

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 COUNTY _____ STATE _____
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21. I attended the deceased from **March 1959** to **April 26, '60** and last saw her alive on **April 28, '60**
Death occurred at **1:00 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George H. Wood M.D.	22b. ADDRESS 1515 Hazel, Carthage, Mo	22c. DATE SIGNED 4-26-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4-28-60	23c. NAME OF CEMETERY OR CREMATORY Robberson Prarie Cem.	23d. LOCATION (City, town, or county) (State) Greene County, Mo
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24. FUNERAL DIRECTOR KNELL MORTUARY	ADDRESS Carthage, Mo	25. DATE RECD. BY LOCAL REG. 4-28-60	26. REGISTRAR'S SIGNATURE WJ Clanton
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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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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.