

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039674

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 294 Primary Registration District No. 2052 Registrar's No. 381

FILED OCT 29 1962			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Pettis</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u> Length of stay in 1b <u>13 days</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bothwell Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>MO</u> b. COUNTY <u>Benton</u></p> <p>c. CITY OR TOWN <u>WARSAW</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>—</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED First Middle Last</p> <p><u>ODA BIRD</u></p> <p>(Type or print)</p>	<p>4. DATE OF DEATH Month Day Year</p> <p><u>Oct 22 1962</u></p>		
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Aug 28, 1892</u></p>
<p>9. AGE (last birthday) <u>70</u></p>	<p>IF UNDER 1 YEAR Months <u>2</u> Days <u>0</u></p>	<p>IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u></p>	<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u></p>
<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u></p>	<p>11. BIRTHPLACE (City and state or country) <u>Fairfield, Mo</u></p>	<p>12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u></p>	
<p>13a. FATHER'S NAME <u>Thomas Crathee</u></p>	<p>13b. MOTHER'S MAIDEN NAME <u>Mary Maxwell</u></p>		
<p>14. NAME OF HUSBAND OR WIFE <u>deceased</u></p>	<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u></p>		
<p>16. SOCIAL SECURITY NO. <u>NO</u></p>	<p>17. INFORMANT <u>Gleed Bird</u> Address <u>Warsaw, Mo</u></p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u></p> <p>DUE TO (b) <u>Myocardial infarction</u></p> <p>DUE TO (c) <u>Arteriosclerosis</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Paralytic ileus; cerebral infarctions; detrusor paralytic; obesity</u></p>		<p>PART III. If deceased was female was there a pregnancy in last 90 days. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>	
<p>20c. TIME OF INJURY Hour Month, Day, Year</p> <p><u>—</u></p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>
<p>21. I attended the deceased from <u>Sept. '62</u> to <u>10-21-62</u> and last saw ^{her}_{him} alive on <u>10-21-62</u></p> <p>Death occurred at <u>1:10 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE <u>Embroider, M.D.</u> (Degree or title)</p>	<p>22b. ADDRESS <u>Warsaw, Mo.</u></p>		
<p>22c. DATE SIGNED <u>10/23/62</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE <u>Oct 24, 1962</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Fairfield Cemetery</u></p>	<p>23d. LOCATION (City, town, or county) (State) <u>Fairfield Benton Co, Mo</u></p>
<p>24. FUNERAL DIRECTOR <u>John F Reser</u> ADDRESS <u>Warsaw</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>Oct. 24, 1962</u></p>		
<p>26. REGISTRAR'S SIGNATURE <u>Frances Shelley, Asst. H. Anderson</u></p>			

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

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OCT 30 1962

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 John F. Reser
Licensed Embalmer No. 4098
P.O. Address Warsaw

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.