

FILED APR 7 1946 -
Registration District No. 1228

Primary Registration District No. 6018

1. PLACE OF DEATH

(a) County Ray Co.
(b) City or town Excelsior Springs
(c) Name of hospital or institution:
1 R. F. D. 2 Jackson Park & Inn
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no (Specify whether)
In this community 87 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray
(c) City or town Excelsior Springs
(If outside city or town limits, write "RURAL")
(d) Street No. PR 27 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LETTIE O'DELL

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Riley Odell 6. (c) Age of husband or wife if alive 87 years
7. Birth date of deceased Feb 22 1856 (Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Ray Mo (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

12. Name Sam Rowland

13. Birthplace Mo (City, town, or county) (State or foreign country)

14. Maiden name Phoebie Odell

15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Riley Odell

(b) Address Excelsior Springs RR # 2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Common

18. (a) Signature of funeral director Robert Hope

(b) Address Excelsior Springs Mo

19. (a) 3/23/43 (Date received local registrar) (b) De O. Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19 year 1943 hour 7:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from March 16th 1943 to March 17 1943 that I last saw her alive on March 17 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to hypertension
Due to arteriosclerosis

Other conditions 0 (Include pregnancy within 3 months of death)

Major findings: Of operations 0

Of autopsy 0

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 0
(b) Date of occurrence 0
(c) Where did injury occur? 0 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury 0
23. Signature R. M. Coaker (M. D. or other) MD.
Address Excelsior Springs Mo Date signed 3/23/43

Duration 4 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 1-6-43

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: _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

James A. Moles
Licensed Embalmer No. 3296

P. O. Address Excelsior Springs

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 this body is not embalmed, fact should be so stated above.