

FILED DEC 13 1944  
383

State File No. \_\_\_\_\_

Registrar's No. 40

Registration District No. 383

Primary Registration District No. 3039

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Marceline  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 2 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn 52  
(c) City or town Marceline  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

James Ira Oden

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 497-14-2209

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife Eva Jane Roof 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov 24 1875  
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Bellerive Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Wilson Oden  
13. Birthplace Bellville Ill.  
(City, town, or county) (State or foreign country)  
14. Maiden name Emily Bowen  
15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sylvia Oden  
(b) Address Summer Mo

17. (a) Burial (b) Date thereof Nov 17 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lakeside Cem Summer Mo

18. (a) Signature of funeral director James M. Laughlin

(b) Address Marceline Mo  
19. (a) 1-16-44 (b) P. J. Patrick M.D.  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16 year 1944 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from Nov. 14 1944 to Nov. 15 1944 that I last saw him alive on Nov. 15 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to Pulmonary Tuberculosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 12  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (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 ?

23. Signature W. S. Bolon M.D. or other \_\_\_\_\_  
Address Marceline Mo Date signed 11-18-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

DEC 18 1944

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 *Dale Bunch*

Licensed Embalmer No. *4088*

P. O. Address *Marletta 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 this body is not embalmed, fact should be so stated above.