

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2363

State File No. ....

FILED FEB 14 1945

Primary Registration District No. 4232

Registrar's No. 29

1. PLACE OF DEATH:  
(a) County Newell  
(b) City or town Willow Springs  
(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 \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Newell 46  
(c) City or town Willow Springs Mo. 2  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 1

3. (a) PRINT FULL NAME WALTER ZACK ODLE  
(b) If veteran, name war No.  
(c) Social Security No. 702-12-8193

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 2 day 2  
year 45 hour 1:30 minute 9 M.  
21. I hereby certify that I attended the deceased from  
8-15- 1939 to 2-2- 1945  
that I last saw him alive on 2-1- 1945  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Leaura (Daugherty) Odle  
6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased June 27 1881  
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion Duration 5 min.  
Due to Arteriosclerosis

8. AGE: Years 64 Months 7 Days 5  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 94a  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Arkansas (City, town, or county) (State or foreign country)  
10. Usual occupation Railroad

11. Industry or business \_\_\_\_\_  
12. Name Agria T. Odle  
13. Birthplace Dont Know (City, town, or county) (State or foreign country)  
14. Maiden name Settie M. Turner  
15. Birthplace Dont Know (City, town, or county) (State or foreign country)

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 \_\_\_\_\_

16. (a) Informant Mrs. Guy Shuckelborg  
(b) Address Earl, Arkansas  
17. (a) Burial (b) Date thereof Feb 4-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director J. J. Burns, Jr.  
(b) Address Willow Springs, Mo.  
19. (a) 25-45 (b) Madette Ferguson  
(Date received local registrar) (Registrar's signature)

23. Signature [Signature] (M. D. certifier)  
Address Willow Springs, Mo. Date signed 2/6/45

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

66-202

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 245-83

Date Filed 2.12.45

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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 D.R. Burns, Jr.

Licensed Embalmer No. 1837

P. O. Address Willow Springs, 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.**