No. 2
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 28 1948

Registration District No. 618

MISSOURI DIVISION OF HEALTH

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 28080

Registrar's No. 7364

**1. PLACE OF DEATH:**

(a) County —

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Evangelical Deaconess Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hrs 9 min (Specify whether
In this community ..... years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis 96

(c) City or town Webster Groves 7
(If outside city or town limits, write "RURAL")

(d) Street No. 545 Marshall Ave 4
(If rural, give location)

N.R.

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3. (a) PRINT FULL NAME Infant ~~Barr~~ Odor

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased August (Month) 22 (Day) 1948 (Year)

8. AGE: Years | Months | Days | If less than one day 2 hr. 9 min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business —

FATHER
12. Name J. Russell Odor
13. Birthplace Abilene (City, town, or county) Texas (State or foreign country)

MOTHER
14. Maiden name Cleo Patricia Chambless
15. Birthplace Seymour (City, town, or county) Texas (State or foreign country)

16. (a) Informant Mrs. J. Odor
(b) Address 545 Marshall Ave

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 23 '48 (Month) (Day) (Year)
(c) Place: burial or cremation OAKHILL CEMETERY

18. (a) Signature of funeral director Mittelberg Guil Home
(b) Address Webster Groves Mo

19. (a) AUG 23 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 22 year 1948 hour 4 minute — a. M.

21. I hereby certify that I attended the deceased from Aug 22, 48 1 5' a.m., 1948 to 4 a.m. Aug 22, 1948 that I last saw her alive on August 22, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Atalectasis

Due to 161

Due to

Other conditions Polycystic Kidneys bilateral. Clubfoot-both
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Congenital Atalectasis, Polycystic Kidneys - Club Feet - Enlarged Liver

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Frances F. Wenzel (M. D. or other) M.D.

Address 5203 Chippewa Date signed 8-27-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

## 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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.