

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3500**

FILED FEB 9 1955

BIRTH NO. **96843-54** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **143**

1. PLACE OF DEATH a. COUNTY St. Louis Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ballwin Mo.		c. CITY OR TOWN 4860 ST. LOUIS COUNTY 0	d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION MRS. MACH HOME		e. STREET ADDRESS (If rural, give location) 651 MAJESTY CT	

3. NAME OF DECEASED (Type or Print)	a. (First) ROBERT	b. (Middle) ALLEN	c. (Last) ODELL	4. DATE OF DEATH (Month) (Day) (Year) 1-18-1955
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 11-25-1954	9. AGE (In years last birthday) 1 MONTHS 24 DAYS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO 0	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME HUMPHRY ODELL	13b. MOTHER'S MAIDEN NAME MARIAN SATTELL	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME HUMPHRY ODELL	ADDRESS 651 MAJESTY
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Meningitis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Meningoencephalocle DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 7.51x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **11/25, 1954**, to **1/18, 1955**, that I last saw the deceased alive on **1/18, 1955**, and that death occurred at **5:25 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Martin H. Caladney M.D.	23b. ADDRESS 4500 OLIVE, ST. LOUIS	23c. DATE SIGNED 1/19/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-20-1955	24c. NAME OF CEMETERY OR CREMATORY LAKEWOOD PARK	24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO.
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DATE REC'D BY LOCAL REG. 1/19/55	REGISTRAR'S SIGNATURE Richard K. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Michael	ADDRESS 5930 Southwest
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

10.48

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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. Allen Rainey*.....

Licensed Embalmer No. *405*.....

P. O. Address *dhj*.....

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.