

FILED JUL 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27339

STATE FILE NUMBER

Registration District No. 379 Primary Registration District No. 4553 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>Wright Co Mo</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mansfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Seymour</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mansfield Hospital 5 Days</u>		d. STREET ADDRESS (If outside, give location) <u>Reside on Farm</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Belle</u> Last <u>Odle</u>		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1875</u>
9. AGE (In years less than 1 year) <u>82</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>AR Kansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH DRENNON</u>	
14. MOTHER'S MAIDEN NAME <u>MARY OWENS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>GIRLIE TAYLOR and MO</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis - Senility</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>July 15 '57</u> to <u>July 20 '57</u> and last saw her/him alive on <u>July 20 '57</u> Death occurred at _____ m on the day stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Wd. Zimmerman D.O.</u>		22b. ADDRESS <u>Mansfield Mo</u>	22c. DATE SIGNED <u>7/25/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-24-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SEYMOUR</u>	23d. LOCATION (City, town, or county) (State) <u>Wright Co Mo</u>
24. FUNERAL DIRECTOR <u>Robert Bergman</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>7/25/57</u>	26. REGISTRAR'S SIGNATURE <u>Ann Perkins</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300  
1-56

AUG 8 1957

RECEIVED 7-27-57  
WRIGHT CO. HEALTH DEPT.  
County File Number 7-27-57  
Date Filed 7-27-57

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 *Max J. Miller* \_\_\_\_\_

Licensed Embalmer No. *47*

P. O. Address *Manfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.